PHOENIX EMA RYAN WHITE TITLE I
HIV Health Services Planning Council

2006 COMPREHENSIVE NEEDS ASSESSMENT

PINAL COUNTY

PREPARED BY:

COLLABORATIVE RESEARCH

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Executive Summary

Annual Needs Assessments are studies conducted to determine priority service needs and gaps in the continuum of care for People Living with HIV/AIDS (PLWHA). Results of this client-centered activity are used to establish service priorities, document the need for specific services, determine barriers to accessing care, provide baseline data for comprehensive planning including capacity building, and help providers improve the access to and quality of services delivered, especially to the designated 'Severe Need Groups'.

HRSA's CARE Act Amendments of 2000 emphasize the identification of those individuals who "know their HIV status and are NOT receiving HIV-related services (those with 'unmet need')." PLWHA who do not access primary medical care for more than a year are deemed 'Out of Care'. The term 'In Care' refers to actively participating in HIV primary medical care, with the documented receipt of one or more of the following three forms of service: use of (1) CD4 lab tests (2) Viral Load lab tests and (3) antiretroviral drugs.[1]

A comprehensive assessment of the service needs of persons living with HIV/AIDS (PLWHAs) and residing in Pinal County of the Phoenix EMA was conducted in January-March of 2006. This four part assessment of need included 1) an "In Care" written survey questionnaire of persons receiving Ryan White funded services utilizing the Needs Assessment Client Survey (NACS) tool; 2) an "In Care" telephone survey questionnaire of rural residents receiving Ryan White funded services utilizing the same survey tool; 3) an 'In Care' written survey of Incarcerated persons receiving Prison Health Services, and 4) an "Out of Care" telephone survey of persons living with HIV/AIDS, but NOT receiving HIV services. (*see Chapter 4 for a complete discussion of findings*).

A Use, Needs, Gaps and Barriers ranking was developed for all 'In Care' respondents, with detail by the six (6) severe need groups[2] as defined by HRSA[3], as well as for the Incarcerated/Recently Released and High Risk Heterosexuals. Client determined priorities drove the overall ranking for service priorities in the County. The 2006 HIV/AIDS Needs Assessment provides a "snapshot" of the community service needs, barriers, and gaps as expressed by consumers of HIV related services.

By nature, the needs assessment process must be ongoing to reflect the changing nature of the consumer base, service delivery system, treatment advances and epidemic trends. To that end, a comparison between the three needs assessment findings (from Community 'In Care', the Incarcerated 'In Care', and the 'Out of Care Surveys') is presented in Chapter 5, and should serve as a baseline for future needs assessment studies.

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[1] 1) **CD4 – CD4 (T4) or CD4 + CELL COUNT and PERCENT**.
2) **VIRAL LOAD TEST** - Test that measures the quantity of HIV RNA in the blood.
3) **ANTIRETROVIRAL DRUGS** - Substances used to interfere with replication or inhibit the multiplication of retroviruses such as HIV.

[2] African American Men having Sex with Men, Anglo MSM, Hispanic MSM, Injection Drug Users, Substance Abusers, Women of Childbearing Age. In addition, we listed the Incarcerated/Recently Released and High Risk Heterosexuals.

[3] HRSA - Health Resources and Services Administration

The rankings of the Needs Assessment were displayed for all 'In Care' respondents, with separation into Need, Use, Gap and Barrier. This can be further defined on the following page as:

Need	Number of 'In Care' client survey respondents who stated "I currently need this service."
Use	Number of 'In Care' client survey respondents who indicated service use in the past year
Gap	Sum of 'In Care' client survey respondents who answered 'Yes' to Need and 'No' to availability of that service
Barrier	Number of 'In Care' client survey respondents who indicated that a service is 'Hard to Get'

These rankings were displayed for ALL Community 'In Care[4]' client survey respondents and ALL Incarcerated 'In Care' client survey respondents, with further separation into rankings by Severe Need Groups, as indicated.

A separate survey was conducted for the 'Out of Care[5]' population, emphasizing expressed service needs and perceived barriers to care. The Out of Care population separates into at least four (4) definable subgroups:

1) Newly diagnosed, not yet receiving services post 3-months of positive diagnosis
2) Erratically out of care – have accessed primary medical services before, are not currently receiving primary medical care and have been out of care over a 6-month period
3) Out of care but not for all services – access support services, not primary medical care for over a 6-month period
4) Never in Care – the most troubling sector, are aware they are HIV+, but have chosen not to receive primary medical services.

I. COMMUNITY 'In Care' Needs Assessment Survey Findings

Table 1: 2006 Community 'In Care' Severe Need Groups

Severe Need Group	#	%
AA MSM	2	6%
Anglo MSM	7	23%
His MSM	4	13%
High Risk HET	10	33%
WCB	5	16%
IDU	3	10%
TOTAL	**30**	**100%**

**** More than one SNG category represented in some cases***

LEGEND:

AA MSM	**African American MSM**
Anglo MSM	**Caucasian MSM**
API MSM	**Asian Pacific Islander APM**
HIS MSM	**Hispanic MSM**
High Risk HET	**High Risk Heterosexuals**
WCB	**Women of Childbearing Age (15-44 years)**
IRR	**Incarcerated/ Recently Released**
SA	**Substance Abuser**
IDU	**Injection Drug User**

[4] In Care – defined by HRSA as receiving 1) Viral Load tests 2) CD4 Count 3) Antiretroviral drugs within the past 12 months

[5] Out of Care – defined by HRSA as NOT receiving primary medical care for period over 12 months. Primary medical care defined as receiving 1) Viral Load tests 2) CD4 Count 3) Antiretroviral drugs

Demographic and Health Profile of ALL <u>Community</u> 'In Care' Survey Respondents:

Demographic representation by the 30 'In Care' Community Survey Respondents was consistent with those of the affected community:

- 70% of all respondents were Male; 20% were Female; and 10% preferred not to answer, reflective of the epidemiologic profile;
- 33% of all respondents identify their transmission risk as Heterosexual; 42% as Homosexual/Gay men; and 10% as IDU; 6% transfusion related; and 3% as Mother with HIV/AIDS; and 6% as risk not reported.
- The majority of respondents were in the 35-54 age range;
- 63% of respondents were Caucasian; 17% were Hispanic; 10% of respondents were African American; 10% identified as "Other Race".
- Representation by Severe Need Group includes the following: 10 Heterosexuals; 7 Anglo MSM; 3 Hispanic MSM; 1 African American MSM; 5 Women of Childbearing Age; and 3 IDU.

Demographic and Risk Profile of 'In Care' <u>Severe Need Group</u> Respondents (other than African American MSM, Anglo MSM and Hispanic MSM, for whom the groupings are self-explanatory)*:*

Table 2: 2006 Demographic/Risk Profile of Community 'In Care' SNG Client Respondents

Severe Need Group/Sub-Set of Severe Need Group	Gender, Race/Ethnicity of SNG Members
Intravenous Drug Users (IDU): 3 'In Care' Respondents	3 Males; 2 White; 1 Hispanic
Women of Childbearing Age (WCB): 5 Female 'In Care' Respondents	5 Females 4 White; 1 Hispanic
High Risk Heterosexuals: 10'In Care' Respondents	5 Males; 5 Females 8 White; 2 Hispanic

The top ranked <u>NEEDS</u> for the Community 'In Care' population by ALL respondents were:

Table 3: Top Ranked Service NEEDS: ALL Community 'In Care' Respondents

Service Category Description	Need Rank
AMBULATORY OUTPATIENT MEDICAL CARE	1
HOUSING ASSISTANCE	2
ORAL HEALTH	3
DRUG REIMBURSEMENT PROGRAM	4
CASE MANAGEMENT	5
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	6
SPECIALTY MEDICAL CARE	7
TRANSPORTATION	7

Table 4: Top Priority Service NEEDS by Community 'In Care' Severe Needs Groups

Anglo MSM	AA MSM	HIS MSM	High Risk HET	WCB	IDU
#1 Ambulatory Medical Care	#1 Ambulatory Medical Care	#1 Ambulatory Medical Care	#1 Ambulatory Medical Care	#1 Ambulatory Medical Care Oral Health**	#1 Ambulatory Medical Care Housing Assistance Oral Health**
#2 Transportation Housing Assistance**	#2 Oral Health Food Bank Housing Assistance Transportation Mental Health**	#2 Oral Health Job Placement**	#2 Drug Reimbursement	#2 Housing Assistance	#2 Psychosocial Support Specialty Medical Care**
#3 Oral Health Job placement Case Management**	*	#3 Buddy/Companion Emergency Financial Assistance Specialty Medical Care**	#3 Oral Health	#3 Transportation	*
#4 Drug Reimbursement Mental Health**	*	*	#4 Case Management	#4 Case Management Food Bank Support Groups**	*
*	*	*	#5 Food Bank Housing Related Assistance Housing Assistance**	*	*

***Indicates no further service rankings offered** ** Indicates service ranking tie*

When asked to rank top priority NEEDS, there is great consistency among the Severe Need Groups in identifying Ambulatory Medical Care as the top priority NEED, followed by Oral Health, Housing Assistance, Food Bank Services, Transportation, Mental Health/Support Groups, Specialty Medical Care and Medications as priority NEEDS.

The 2006 Pinal County NEEDS Matrix below compares the NEEDS rankings by ALL Community 'In Care' Respondents versus NEEDS Rankings by each SNG:

2006 PINAL COUNTY NEEDS MATRIX	ALL N=30		SEVERE	NEED	GROUPS		
Service Category	**2006 Overall Rank (N=30)**	**Anglo MSM**	**AA MSM**	**HIS MSM**	**High Risk HET**	**WCB**	**IDU**
Ambulatory Outpatient Medical Care	**1**	1	1	1	1	1	1
Housing Assistance	**2**	2	2	*	5	2	1
Oral Health	**3**	3	2	2	3	1	1
Drug Reimbursement Program	**4**	4	*	2	2	*	*
Case Management	**5**	3	*	*	4	4	*
Food Bank Services	**6**	*	2	*	5	4	*
Transportation	**7**	2	2	*	*	3	*
Specialty Medical Care	**7**	*	*	3	*	*	2
Buddy/Companion Services	**8**	*	*	3	*	*	*
Housing Related Services	**8**	*	*	*	5	*	*
Mental Health	**8**	4	2	*	*	*	*
Psychosocial Support	**8**	*	*	*	*	*	2
Support Groups	**8**	*	*	*	*	4	*
Emergency Financial Assistance	**8**	*	*	3	*	*	*
Job Placement	*****	3	*	2	*	*	*

As strikingly evident when viewed in the above comparison table, Ambulatory Medical Care is consistently ranked as the #1 service priority NEED by the entire group of 'In Care' respondents as well as by all the Severe Need Groups. There is also substantial consistency among all populations regarding the multiple #2 ranked priority NEEDS, including: Housing Assistance, Oral health, and

Drug Reimbursement Program. Case Management, Food Bank, and Transportation also receive high rankings as priority service needs.

The top 14 highest ranking NEEDED and USED services by ALL respondents are *identical, except for Housing Assistance, which ranks as a high priority need, but low use ranking (further explained below under 'Gap section'). Both Support Groups and Emergency Financial Assistance are also identified as service gaps and barriers, as discussed below.*

Table 5: Service NEEDS Compared to Services US ES: ALL Community 'In Care' Respondents

Service Category Description	Need Rank	Use Rank
AMBULATORY OUTPATIENT MEDICAL CARE	1	1
HOUSING ASSISTANCE	2	8
ORAL HEALTH -DENTAL	3	2
DRUG REIMBURSEMENT PROGRAM	4	3
CASE MANAGEMENT	5	4
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	6	6
SPECIALTY MEDICAL CARE	7	6
TRANSPORTATION	7	5
BUDDY/COMPANION	8	7
EMERGENCY FINANCIAL ASSISTANCE	8	8
HOUSING RELATED SERVICES	8	7
MENTAL HEALTH	8	7
PSYCHOSOCIAL SUPPORT	8	7
SUPPORT GROUPS	8	8

The top ten ranked <u>GAPS</u> in services needed but perceived as inaccessible for ALL respondents, evidenced in the table below, were:

Table 6: Top 10 Service GAPS: ALL Community 'In Care' Respondents

Service Category Description	Gap Rank
SPECIALTY MEDICAL CARE	1
VISION CARE	2
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	3
SUPPORT GROUPS	4
ORAL HEALTH -DENTAL	5
EMERGENCY FINANCIAL ASSISTANCE	6
ALTERNATIVE THERAPIES	6
JOB PLACEMENT	6
RURAL ACCESS	6
HOUSING ASSISTANCE	6

Table 7: Top Priority Service GAPS by Community 'In Care' Severe Needs Groups

Anglo MSM	AA MSM	HIS MSM	HET	WCB	IDU
#1 Job Placement	#1 Food Bank	#1 Support Groups	#1 Specialty Medical	#1 Housing Assistance	#1 Support Groups
#1 Vision Care	#1 Support Groups	#2 Alternative Therapies	#2 Emergency Financial Assistance	#1 Nutrition Counseling	#2 Emergency Financial Assistance
*	*	#3 Emergency Financial Assistance	#3 Drug Reimbursement Program	*	#2 Specialty Medical
*	*	*	#4 Nutrition Counseling	*	*
*	*	*	#4 Vision Care	*	*

Indicates no further service rankings offered

There is a high level of consistency among all of the Severe Need Groups as to perceived GAPS. *Support groups, Emergency Financial Assistance, Nutrition Counseling, and Vision Care are all ranked as priority service GAPS, perceived as 'unavailable' by two or more SNGs.*

The top three ranked BARRIERS to needed services that are perceived as hardest to access by ALL respondents and would prevent the 'In Care' from remaining in care are:

1. **Transportation**
2. **Rural Access**
3. **Emergency Financial Assistance**

While ALL the survey respondents as a whole only ranked three services as BARRIERS in this section of the survey, *two of the top three ranking service BARRIERS (Rural Access and Emergency Financial Assistance) also represent some of the highest ranking service NEEDS and service GAPS by the entire population of 'In Care' survey respondents.*

Table 8: 2006 Highest Ranking BARRIERS for all Community 'In Care' Severe Need Groups

Anglo MSM	AA MSM	HIS MSM	HET	WCB	IDU
#1 Food Bank	#1 Ambulatory Medical Care	#1 Ambulatory Medical Care	#1 Transportation	#1 Food Bank	#1 Transportation
#2 Transportation	#1 Food Bank	#1 Support Groups	#2 Rural Access	#2 Transportation	#1 Food Bank
#3 Early Intervention	#1 Transportation	#1 Food Bank	#3 Early Intervention	#3 Ambulatory Medical Care	#1 Rural Access
#3 Rural Access	#1 Rural Access	#1 Rural Access	*	#4 Rural Access	#2 Early Intervention

Indicates no further service rankings offered

II. INCARCERATED Population of 'In Care' Survey Respondents

Table 9: 2006 Incarcerated 'In Care' Severe Need Groups

Severe Need Group	#	%
AA MSM	2	6%
Anglo MSM	1	23%
High Risk HET	9	33%
IDU	4	10%
IRR TOTAL	**16**	**100%**

LEGEND:

AA MSM	**African American MSM**
Anglo MSM	**Caucasian MSM**
API MSM	**Asian Pacific Islander APM**
HIS MSM	**Hispanic MSM**
High Risk HET	**High Risk Heterosexuals**
WCB	**Women of Childbearing Age (15-44 years)**
IRR	**Incarcerated/ Recently Released**
SA	**Substance Abuser**
IDU	**Injection Drug User**

Demographic and Health Profile of ALL <u>Incarcerated</u> 'In Care' Survey Respondents:

Demographic representation by the 16 'In Care' Incarcerated Survey Respondents was consistent with those of the affected community:

- 100% of all respondents were Male; reflective of the IRR profile;
- 56% of all respondents identify their transmission risk as Heterosexual; 19% as Homosexual/Gay men; and 25% as IDU;
- 93% of the respondents were in the 25-54 age range;
- 31% of respondents were Caucasian; 25% were Hispanic; 38% of respondents were African American; 6% identified as American Indian.
- Representation by Severe Need Group includes the following: 9 Heterosexuals; 1 Anglo MSM; 2 African American MSM; and 4 IDU.

The top ranked <u>NEEDS</u> for the Incarcerated 'In Care' population by ALL respondents:

Table 10: 2006 Service NEEDS: ALL Incarcerated 'In Care' Respondents

Service Category Description	Need Rank
AMBULATORY OUTPATIENT MEDICAL CARE	1
HOUSING ASSISTANCE	2
DRUG REIMBURSEMENT PROGRAM	3
CASE MANAGEMENT	4
TRANSPORTATION	5
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	6
JOB PLACEMENT	7
MENTAL HEALTH	7
ORAL HEALTH -DENTAL	7
SUBSTANCE ABUSE SERVICES	7

The top ranked NEEDS for the Incarcerated 'In Care' population by HRH respondents:

Table 11: Service NEEDS: High Risk Heterosexual Incarcerated 'In Care' Respondents

Service Category Description	Need Rank
HOUSING ASSISTANCE	1
AMBULATORY OUTPATIENT MEDICAL CARE	2
DRUG REIMBURSEMENT PROGRAM	2
CASE MANAGEMENT	3
TRANSPORTATION	4
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	5
JOB PLACEMENT	6
MENTAL HEALTH	6
ORAL HEALTH -DENTAL	6
SUBSTANCE ABUSE SERVICES	6

The top ranked NEEDS for the Incarcerated 'In Care' population by Anglo MSM respondents:

Table 12: Service NEEDS: Anglo MSM Incarcerated 'In Care' Respondents

Service Category Descr iption	Need Rank
AMBULATORY OUTPATIENT MEDICAL CARE	1
CASE MANAGEMENT	1
DRUG REIMBURSEMENT PROGRAM	1

The top ranked NEEDS for the Incarcerated 'In Care' population by AA MSM respondents:

Table 13: Service NEEDS: African American MSM Incarcerated 'In Care' Respondents

Service Category Description	Need Rank
AMBULATORY OUTPATIENT MEDICAL CARE	1
HOUSING ASSISTANCE	2
TRANSPORTATION	2

The top ranked NEEDS for the Incarcerated 'In Care' population by IDU respondents:

Table 14: Service NEEDS: IDU Incarcerated 'In Care' Respondents

Service Category Description	Need Rank
HOUSING ASSISTANCE	1
AMBULATORY OUTPATIENT MEDICAL CARE	2
TRANSPORTATION	2
DRUG REIMBURSEMENT PROGRAM	3
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	3
JOB PLACEMENT	3

Among the Severe Need Groups, the top ranking NEEDS are identical, though some services receive higher rank ordering than others among the Severe Need Groups. Consistently, ALL of the Incarcerated 'In Care' population, and each of the Severe Need Groups identify Ambulatory Medical Care Housing Assistance, Food Bank Services, Transportation, Medications, and Job placement as priority NEEDS. Case management, oral health, mental health and substance abuse services also receive high rankings as priority needs by members of the Incarcerated 'In Care' population.

III. 'Out of Care' Population of Survey Respondents

Demographic and Health Profile of 'Out of Care' Respondents

Of the total OOC sample, all 15 respondents were Male (100%). Over half (53%) of the entire OOC population identifies as Homosexual/Gay; 27% as Heterosexual, and 20% as Bisexual. An additional 4 respondents (27%) report a history of IDU. The entire OOC population was between the ages of 25 and 54 years. The racial/ethnic make-up of the 'Out of Care' population is entirely Anglo/Caucasian.

Table 15. 2006 OOC Survey Respondent Profile

Out Of Care:			
Severe Need Group	'n'	%	Demographic Profile (Gender/Race/Risk)
Anglo MSM	8	53%	8 Anglo Male MSM
HET MALE	4	27%	4 Anglo Male HET
Bisexual	2	13%	2 Anglo Males
IDU	4	27%	2 Male Anglo HET; 2 Male Anglo MSM
TOTAL	*15	100%	

**** More than one SNG category represented in some cases***

LEGEND:

AA MSM	African American MSM
Anglo MSM	Caucasian MSM
HIS MSM	Hispanic MSM
Het Male	Heterosexual Male
WCB	Women of Childbearing Age (15-44 years)
IRR	Incarcerated/ Recently Released
SA	Substance Abuser
IDU	Injection Drug User

The top three ranked <u>NEEDS</u> and four top ranked <u>USES</u> for the 'Out of Care' population by ALL respondents were:

Table 16: Priority Service NEEDS and USES: ALL OOC Respondents

Service Category Description	Need Rank	Use Rank
HOUSING ASSISTANCE	1	1
AMBULATORY OUTPATIENT MEDICAL CARE	2	2
OUTREACH	3	3
CASE MANAGEMENT	4	4

Table 17: Top Priority NEEDS and USES: Anglo MSM SNG

Service Category Description	Need Rank	Use Rank
TRANSPORTATION	1	3
AMBULATORY OUTPATIENT MEDICAL CARE	2	1
OUTREACH	3	2

Table 18: Top Priority NEEDS and USES by High Risk HET SNG

Service Category Description	Need Rank	Use Rank
HOUSING ASSISTANCE	1	2
AMBULATORY OUTPATIENT MEDICAL CARE	2	1

Table 19: Top Priority NEEDS and USES by IDU SNG

Service Category Description	Need Rank	Use Rank
HOUSING ASSISTANCE	1	1
OUTREACH	2	2

The **NEEDS** rankings of the Severe Need Groups are highly congruent, overall, with the expressed needs of the entire 'Out of Care' population. This consistent expression of need is particularly evident in the number of *top three NEED rankings for primary medical care, housing assistance and outreach.*

The top ranked and only GAP perceived as unavailable for the entire 'Out of Care' population by ALL respondents was 'job placement services':

Service Category Description	Gap Rank
JOB PLACEMENT	1

Reasons given by the entire OOC population for why job placement services are unavailable include:

Table 20: 'Out of Care' GAP Explanations

GAP Explanations	#	%
RURAL LOCATION	10	77%
SERVICE REIMBURSEMENT DISCONTINUED	1	8%
INSURANCE	1	8%
INCOME ABOVE REQUIREMENT	1	8%
TOTAL	**13**	**100%**

Top Priority GAP Rankings by Severe Need Groups:

- **Anglo MSM: Oral Health/Dental Services**
- **HRH: Oral Health/Dental Care Services**
- **IDU: Job Placement Services**

The only Service <u>BARRIER</u> identified as 'hard to get' by the entire OOC population includes Oral Health/Dental Care Services:

Table 21: 'Out of Care' BARRIER

SERVICES	#	%
DENTAL CARE	8	100%
TOTAL	**8**	**100%**

Reasons supplied by the OOC population for this perceived dental care service barrier include:

Table 22: OOC BARRIER Explanations

BARRIER EXPLANATIONS	#	%
JUST NOT EASILY ACCESSIBLE	3	38%
TRANSPORTATION	4	50%
INCOME ELIGIBILITY	1	13%
TOTAL	**8**	**100%**

For the Severe Need Groups, perceived GAPS and BARRIERS are consistently Dental Care Services and Job Placement Services, ranking highest for the services perceived as either unavailable or hard to access.

Chapter 1. Description of Pinal County within the Phoenix EMA

Overview of Population Statistics

Population

Arizona was the second fastest growing state in the nation in the 1990s. Arizona's July 1, 2004 population reached 5.83 million, according to the latest estimates from the Arizona Department of Economic Security Population Statistics Unit. The Arizona population is expected to reach over 11.17 million by 2050, a 118% increase of the state's population from 5.13 million in 2000.

Arizona and Phoenix EMA Population Demographics

Arizona's population is predominantly White. White non-Hispanics comprise 62% of the State's population. Hispanics make up 27% of the State's population; non-Hispanic Blacks comprise 3.2% of the total population; Asian-Pacific Islander non-Hispanics make up 2.2% of the State's total population; and, American Indian/Alaska Native non-Hispanics comprise 4.8% of the State's population (2003).

Maricopa County (Phoenix Metropolitan Area) makes up 60.7% of the State's population, and 68% of the prevalent cases of HIV/AIDS and 71.3% of the emergent cases of HIV/AIDS.

Pinal County holds the third highest HIV/AIDS prevalence rate (162.14) next to Pima and Maricopa counties. *Approximately 30% of the prevent cases and 60% of the emergent cases of HIV/AIDS in Pinal County are attributable to the incarcerated persons residing there.*

Geography of Pinal County

Arizona is made up of two largely urban and 13 rural counties. Pinal County, considered a rural county, is located in south-central Arizona and was formed from portions of Maricopa and Pima counties in 1875. Florence was designated the county seat and is home to both the Pinal County government complex and the Arizona State Prison. Pinal County is the third largest county in Arizona.

Pinal County encompasses 5,374 square miles and is made up of two distinct regions: the eastern mountainous portion and the western portion, comprised of primarily low desert valleys. This mixed geography presents challenges in attempting to meet the varied and widespread health coverage issues of the HIV/AIDS population. Incorporated cities include: Apache Junction; Superior, Kearney; Florence; Coolidge; Casa Grande; Eloy; and Mammoth. (*See* Figure 1 on the following page, for a map of Pinal County)

Figure 1. PINAL COUNTY

Demographics

The population of Pinal County increased 54.4% from 1990 to 2000, and now totals 229,549 persons (2005). Pinal County is the 7th fastest growing county in the nation among those counties with populations greater than 10,000 persons. The County continues to grow at a 6.9% rate of increase (*USA Today*, March 15, 2005). Pinal County's racial composition is similar to that of Arizona as a whole, with approximately 89% of the population represented by White or Hispanic demographic categories. The population of Pinal County is composed of 29.9% persons of Hispanic ethnicity; with racial composition including: 70.4% white; 2.8% African American; 7.8% American Indian; 0.7% Asian/Pacific Islander; and 18.4% other/mixed race. The median age of the population is 37.1 years, which is three years higher than the State's median age of 34.2 years. Females make up 46.7% of the population.

Socioeconomics

Pinal County's major industries include government, services, trade, manufacturing and agriculture. Pinal County has a 5.4% unemployment rate. 72.7% are high school graduates (below average when compared to Arizona), and 11.9% hold a college degree (2004).

The per capita personal income in Pinal County in 2002 was $19,356, which represents 63% of the national per capita income (in 2002) of $30,906. In comparison, the per capita income for the state of Arizona was $20,756. The median household income (2000) in Pinal County was $35,856, translating into the fact that 16.9% of the population is composed of persons living below the poverty level (compared to13.9% for all of Arizona). The Pinal County per capita personal income rate has been on the decline since 1993. Possible reasons for this include: 1) a larger than average portion of the population is retired; and 2) the mix of jobs has shifted from high wage mining to typically lower

paying State and local government-related, trade and services jobs (Arizona Statewide Economic Study, 2002). Per capita income by race/ethnicity evidences substantial disparities, with Native Hawaiian/Pacific Islander residents of Pinal County earning less than half the per capita average, at $6,461 per year; American Indians earning only slightly more, at $6,913 per year; and Blacks earning approximately half the Pinal County per capita income, at $8,620 per year.

Affected Community

Arizona currently has 10,294 persons known to be living with HIV or AIDS (5/1/05, ADHS Integrated Epidemiologic Profile). A total of 17,987 confirmed cases of HIV or AIDS have been reported. The State as a whole has a known HIV disease prevalence rate of 184.5 per 100,000 persons. *Based on current prevalence estimates, at least one of every 542 persons in Arizona has HIV.* Arizona utilizes the Epidemic Impact Factor (EIF) to evaluate the impact of HIV disease on urban and rural counties. According to the 2005 Integrated Epidemiologic Profile (ADHS), a total of 668 women (52.3% of the total prevalent female population) and 4,217 men living with HIV/AIDS (49.9% of the total prevalent male population) are NOT in CARE in Arizona. Black non-Hispanics are more likely to be found with an 'unmet need' than any other group (56.2% are NOT in CARE). Persons who report IDU as their primary risk behavior are more likely than other risk groups to be out of care.

Pinal County has the third highest number of prevalent cases (331) in the State, yielding an HIV/AIDS prevalence case rate of 162.14 per 100,000 persons. Pinal County's emergent case rate (15.38 per 100,000 persons) is the second highest in the State, having 145 emergent cases of HIV/AIDS reported from 1999 to 2003 (2005 Integrated Epidemiologic Profile, ADHS).

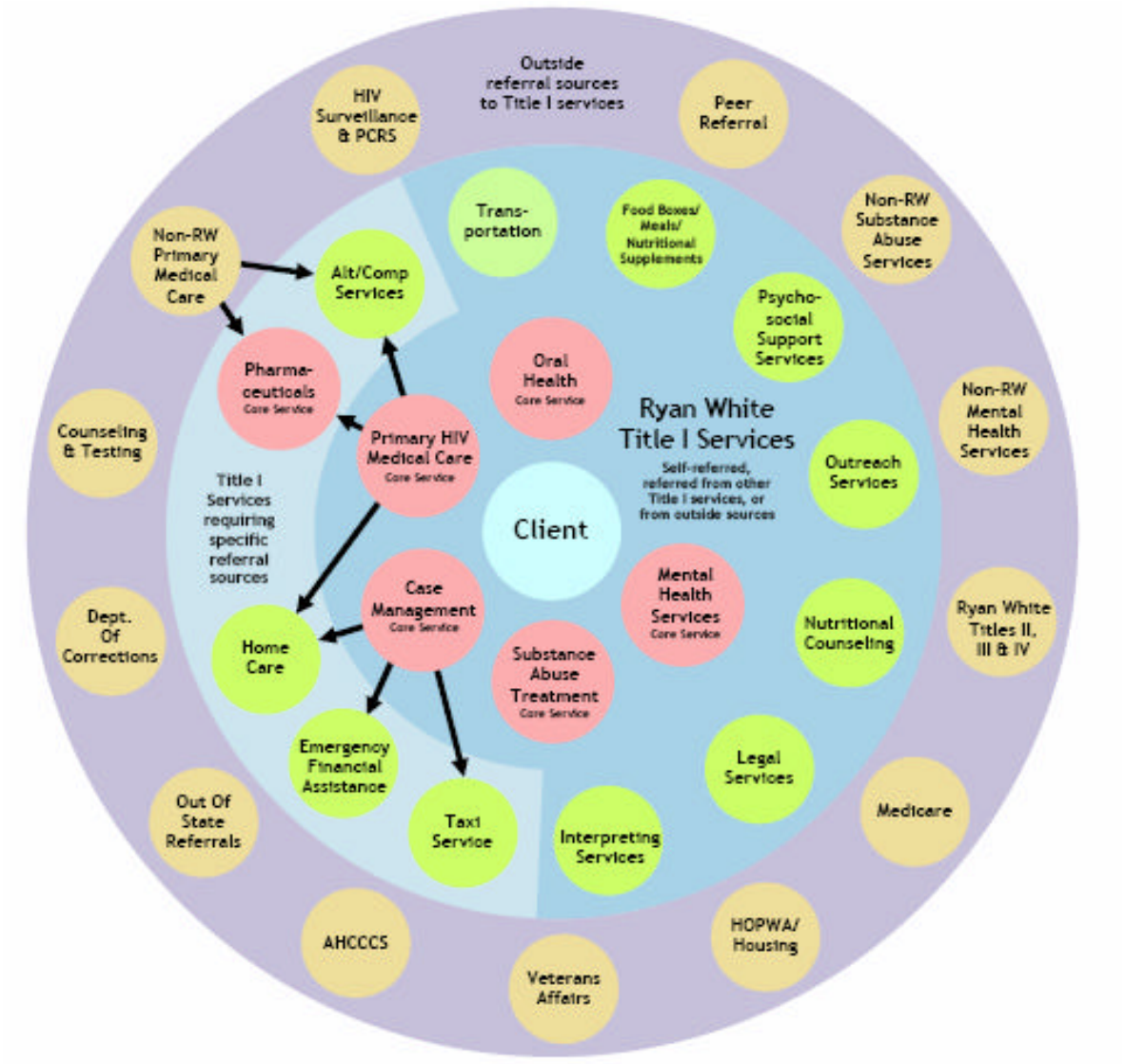
The prison population makes a significant impact on the HIV epidemic in Pinal County. Prisoners make up 5.2% of the total population of Pinal County, yet comprise almost 30% of the County's prevalent cases (99 of 331 persons) and almost 60% of the emergent cases in Pinal County. (2005 ADHS) In Arizona, inmates are NOT routinely screened for HIV upon Intake or at discharge. According to current prison policies, inmates may only be tested for HIV/AIDS upon request. *Therefore, the number of reported HIV infections that occur while in prison is thought to be a fraction of the totality of HIV prevalence among prison populations* (2005 Integrated Epidemiologic Profile, ADHS). Despite this fact, the prevalence of HIV infection in Arizona prisons is 0.7%, which is 3.7 times the estimated rate of HIV infection in the general population of Arizona. *HIV testing performed in 2004 yielded a 1.3% positivity rate, which translates into 7 times the estimated rate of HIV infection in the general population.* Again, given the fact that these HIV test results were only among those specifically requesting HIV testing, the actual number of HIV cases among inmates is likely greatly underrepresented. ***The Prison currently houses 148 HIV-positive Inmates and reports releasing approximately 120 HIV-positive Inmates into the community each year (Arizona Department of Corrections).***

Service Coverage

Ryan White Title I, Title II, Title III and IV funded agencies form the network of medical and community based organizations that compose the Continuum of Care in the Phoenix EMA. Title I supports primary medical care, case management, dental care, drug reimbursement, home health, hospice/residential, mental health, substance abuse counseling and family support services in addition to supporting the Planning Council. Title II funds outpatient medical care, medications, dental care, mental health and substance abuse treatment services and other social services that enable PLWH to access care including client advocacy, direct emergency financial assistance, housing assistance and

residential housing services, nutritional services including food bank and home delivered meals, and transportation. Early intervention/primary medical care services have historically been funded through Title III with Title IV supporting clinics throughout the EMA for medical and support services to women, children, youth and families. The location of these providers is a significant issue for the Pinal County population that is geographically distant, with a client base with limited transportation resources.

Phoenix EMA Continuum of Care



Chapter 2 Epidemiological Profile

Executive Summary

The Epidemiological Profile serves as the baseline for all other calculations.

> **Prevalence** estimates the current population living with the HIV or AIDS infection.
>
> **Emergence** measures the emerging disease pattern, or those persons newly diagnosed with the disease within the past four years. The emergent diagnosis is the earliest report of HIV infection for each person. Those first diagnosed as HIV would be emergent HIV cases, and those first diagnosed as AIDS would be emergent AIDS.

This profile describes the current and emerging status of HIV/AIDS in Pinal County and compares rates (whether prevalence or emergence) to those of Arizona where appropriate.

1. Arizona, Phoenix EMA and Pinal County HIV/AIDS Statistics

Table 23: ARIZONA EMERGENT HIV/AIDS, PREVALENT HIV/AIDS, AND STATE POPULATION BY COUNTY

	Current HIV/AIDS Prevalence			Emergent HIV/AIDS 1999-2003			2003 Population Estimates		
COUNTY	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Population	% State Total	Population Density (people per sq. mile)
Apache	26	0.3%	38.16	18	0.5%	5.25	68,129	1.2%	6.1
Cochise	117	1.1%	95.78	32	0.9%	5.37	122,161	2.2%	19.7
Coconino	120	1.1%	98.93	41	1.2%	6.93	121,301	2.2%	6.5
Gila	25	0.2%	48.59	6	0.2%	2.34	51,448	0.9%	10.7
Graham	29	0.3%	87.74	17	0.5%	10.21	33,051	0.6%	7.1
Greenlee	2	0.0%	26.61	0	0.0%	0.00	7,517	0.1%	4.1
LaPaz	21	0.2%	107.60	7	0.2%	7.17	19,517	0.3%	4.3
Maricopa	7,010	68.1%	206.83	2,509	71.3%	15.68	3,389,260	60.7%	367.5
Mohave	173	1.7%	100.95	42	1.2%	5.23	171,367	3.1%	12.7
Navajo	45	0.4%	43.15	29	0.8%	5.80	104,280	1.9%	10.5
Pima	1,903	18.5%	213.15	576	16.4%	13.35	892,798	16.0%	97.2
Pinal	331	3.2%	162.14	145	4.1%	15.38	204,148	3.7%	38.0
Santa Cruz	29	0.3%	72.02	12	0.3%	6.13	40,267	0.7%	32.6
Yavapai	130	1.3%	70.49	47	1.3%	5.41	184,433	3.3%	22.7
Yuma	128	1.2%	74.80	38	1.1%	4.64	171,134	3.1%	31.0
Unknown	205	2.0%	N/A	0	0.0%	N/A	N/A	N/A	N/A
TOTAL	10,294	100.0%	184.45	3,519	100.0%	13.26	5,580,811	100.0%	49.0

Source: Arizona HARS 5/1/05; NCHS 1999-2003 Bridged-Race Intercensal Estimates. (Adapted from the Integrated Epidemiologic Profile, ADHS, 2005)

Pinal County ranks third among all counties in the State for its prevalent case rate, and ranks second only to Maricopa county for its emergent HIV/AIDS case rate.

Table 24: CURRENT ESTIMATED PREVALENCE: PINAL COUNTY

	Prevalent HIV			Prevalent AIDS			Prevalent HIV/AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	137	42.0	126.56	148	45.4	136.72	285	87.4	263.28
Female	25	7.7	26.07	16	4.9	16.68	41	12.6	42.75
	162	49.7	79.35	164	50.3	80.33	326	100.0	159.69
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	2	0.6	6.30	0	0.0	0.00	2	0.6	6.30
13-19	0	0.0	0.00	2	0.6	9.78	2	0.6	9.78
20-24	2	0.6	13.15	1	0.3	6.58	3	0.9	19.73
25-29	18	5.5	126.24	5	1.5	35.07	23	7.1	161.31
30-34	32	9.8	232.69	26	8.0	189.06	58	17.8	421.76
35-39	47	14.4	352.38	42	12.9	314.89	89	27.3	667.27
40-44	29	8.9	208.93	31	9.5	223.34	60	18.4	432.28
45-49	11	3.4	88.92	29	8.9	234.42	40	12.3	323.34
50-54	10	3.1	88.64	14	4.3	124.10	24	7.4	212.75
55-59	5	1.5	45.67	5	1.5	45.67	10	3.1	91.34
60-64	3	0.9	28.28	4	1.2	37.70	7	2.1	65.98
65 and Above	2	0.6	6.51	5	1.5	16.28	7	2.1	22.79
Age Unknown	1	0.3	N/A	0	0.0	N/A	1	0.3	N/A
	162	49.7	79.35	164	50.3	80.33	326	100.0	159.69
White Non-Hispanic	62	19.0	51.87	66	20.2	55.22	128	39.3	107.09
Black Non-Hispanic	15	4.6	246.59	15	4.6	246.59	30	9.2	493.18
Hispanic	67	20.6	107.67	75	23.0	120.53	142	43.6	228.20
***A/PI/H Non-Hispanic**	4	1.2	235.57	1	0.3	58.89	5	1.5	294.46
****AI/AN Non-Hispanic**	12	3.7	82.13	7	2.1	47.91	19	5.8	130.04
*****MR/O Non-Hispanic**	2	0.6	N/A	0	0.0	N/A	2	0.6	N/A
	162	49.7	79.35	164	50.3	80.33	326	100.0	159.69
+MSM	52	16.0	N/A	61	18.7	N/A	113	34.7	N/A
++IDU	45	13.8	N/A	43	13.2	N/A	88	27.0	N/A
	18	5.5	N/A	37	11.3	N/A	55	16.9	N/A
Heterosexual	19	5.8	N/A	16	4.9	N/A	35	10.7	N/A
+++O/H/TF/TPR	3	0.9	N/A	1	0.3	N/A	4	1.2	N/A
++++NRR/UR	25	7.7	N/A	6	1.8	N/A	31	9.5	N/A
	162	49.7	79.35	164	50.3	80.33	326	100.0	159.69

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Mult iple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

The state of Arizona as a whole has a known HIV disease prevalence rate of 182.7 per 100,000 persons, up slightly from 178.0 in 2004. Based on current prevalence estimates (3/2005) at least 1 of every 547 persons in Arizona has HIV. (Executive Summary, State of Arizona HIV/AIDS Annual Report, March 2005)

Pinal County, as a rural county, has an estimated prevalence rate of 162.14 per 100,000, and a five-year incidence rate equal to that of Maricopa County, the most urbanized county in the state. (Executive Summary, State of Arizona HIV/AIDS Annual Report, March 2005)

Table 25: PINAL COUNTY INCIDENCE; 1994-1998

	Emergent HIV			Emergent AIDS			Emergent HIV/AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	35	50.7	8.75	24	34.8	6.00	59	85.5	14.75
Female	5	7.2	1.39	5	7.2	1.39	10	14.5	2.77
	40	58.0	5.26	29	42.0	3.81	69	100.0	9.07
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	1	1.4	0.82	0	0.0	0.00	1	1.4	0.82
13-19	2	2.9	2.72	0	0.0	0.00	2	2.9	2.72
20-24	3	4.3	6.60	1	1.4	2.20	4	5.8	8.80
25-29	8	11.6	15.51	3	4.3	5.82	11	15.9	21.32
30-34	11	15.9	19.50	5	7.2	8.86	16	23.2	28.36
35-39	4	5.8	6.93	7	10.1	12.13	11	15.9	19.07
40-44	5	7.2	9.78	4	5.8	7.82	9	13.0	17.60
45-49	2	2.9	4.44	3	4.3	6.65	5	7.2	11.09
50-54	2	2.9	5.12	3	4.3	7.69	5	7.2	12.81
55-59	2	2.9	5.51	0	0.0	0.00	2	2.9	5.51
60-64	0	0.0	0.00	2	2.9	5.33	2	2.9	5.33
65 and Above	0	0.0	0.00	1	1.4	0.82	1	1.4	0.82
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
	40	58.0	5.26	29	42.0	3.81	69	100.0	9.07
White Non-Hispanic	25	36.2	5.51	15	21.7	3.31	40	58.0	8.81
Black Non-Hispanic	1	1.4	4.65	4	5.8	18.62	5	7.2	23.27
Hispanic	12	17.4	5.37	8	11.6	3.58	20	29.0	8.96
***A/PI/H Non-Hispanic**	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
****AI/AN Non-Hispanic**	2	2.9	3.45	1	1.4	1.72	3	4.3	5.17
*****MR/O Non-Hispanic**	0	0.0	N/A	1	1.4	N/A	1	1.4	N/A
	40	58.0	5.26	29	42.0	3.81	69	100.0	9.07
[+]MSM	17	24.6	N/A	11	15.9	N/A	28	40.6	N/A
[++]IDU	8	11.6	N/A	5	7.2	N/A	13	18.8	N/A
	5	7.2	N/A	1	1.4	N/A	6	8.7	N/A
Heterosexual	6	8.7	N/A	6	8.7	N/A	12	17.4	N/A
[+++]O/H/TF/TPR	1	1.4	N/A	0	0.0	N/A	1	1.4	N/A
[++++]NRR/UR	3	4.3	N/A	6	8.7	N/A	9	13.0	N/A
	40	58.0	5.26	29	42.0	3.81	69	100.0	9.07

* Asian Pacific/Islander/Hawaiian
** American Indian/Alaskan Native
*** Multiple Race/Other Race

\+ Men having Sex with Men
++ Injection Drug Use
+++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient
++++ No Reported Risk/Unknown Risk

Between 1999 and 2003 in Arizona, more emergent HIV infections were found in the 35-39 year age range than in any other group (717), followed by the 30-34 year age group (635), followed by the 40-44 year age group (575). In Pinal County, the age group most affected by emergent HIV infection is the 30-34 year age group, followed by the 25-29 year age group, evidencing a younger HIV population in Pinal County than for the state as a whole. (Executive Summary, State of Arizona HIV/AIDS Annual Report, March 2005)

Trends of emergent HIV infection among all racial/ethnic groups in Arizona are reflective of broader population trends, with the clear exception of non-Hispanic Blacks. Non-Hispanic Blacks were just 3.2% of Arizona's population in 2003, but accounted for 12.9% of emergent HIV infection. This 3 to 4 fold disproportionate impact is not seen among other minority groups. In 2003, Hispanics of all races

were 27.8% of the state population and 30.8% of the emergent HIV infection. American Indian/Alaska Natives were 4.8% of the state's population in 2003 and 4.8% of emergent HIV infection. Asian/Pacific Islanders were 2.2% of the state's population in 2003 and 0.7% of emergent HIV infection. (Executive Summary, State of Arizona HIV/AIDS Annual Report, March 2005)

The predominant risk behavior associated with emergent HIV infection in Arizona is MSM behavior, which comprised 71.5% of all emergent HIV infections in 2003. IDU is the second most frequently reported behavior associated with emergent HIV infection. HRH was associated with 12.6% of emergent HIV infection reports. Among all risk categories, MSM and HRH are the only categories that appear to be increasing as a proportion of emergent HIV infection in Arizona. (Executive Summary, State of Arizona HIV/AIDS Annual Report, March 2005)

Table 26: PINAL COUNTY INCIDENCE: 1999-2003

	Emergent HIV			Emergent AIDS			Emergent HIV/AIDS		
	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000	Cases	% Region Total	Rate Per 100,000
By Gender									
Male	76	51.7	15.16	52	35.4	10.38	128	87.1	25.54
Female	11	7.5	2.49	8	5.4	1.81	19	12.9	4.30
	87	59.2	9.23	60	40.8	6.36	147	100.0	15.59
Under 2	0	0.0	0.00	0	0.0	0.00	0	0.0	0.00
2-12	1	0.7	0.68	1	0.7	0.68	2	1.4	1.36
13-19	1	0.7	1.08	1	0.7	1.08	2	1.4	2.17
20-24	9	6.1	14.43	2	1.4	3.21	11	7.5	17.63
25-29	14	9.5	22.28	6	4.1	9.55	20	13.6	31.82
30-34	18	12.2	29.06	12	8.2	19.37	30	20.4	48.43
35-39	20	13.6	30.67	17	11.6	26.07	37	25.2	56.75
40-44	10	6.8	15.54	14	9.5	21.75	24	16.3	37.29
45-49	9	6.1	15.57	4	2.7	6.92	13	8.8	22.50
50-54	2	1.4	3.77	0	0.0	0.00	2	1.4	3.77
55-59	1	0.7	1.98	2	1.4	3.97	3	2.0	5.95
60-64	1	0.7	2.01	0	0.0	0.00	1	0.7	2.01
65 and Above	1	0.7	0.66	1	0.7	0.66	2	1.4	1.33
Age Unknown	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
	87	59.2	9.23	60	40.8	6.36	147	100.0	15.59
White Non-Hispanic	28	19.0	5.03	16	10.9	2.87	44	29.9	7.90
Black Non-Hispanic	14	9.5	52.41	5	3.4	18.72	19	12.9	71.13
Hispanic	35	23.8	12.32	34	23.1	11.97	69	46.9	24.30
***A/PI/H Non-Hispanic**	4	2.7	57.45	0	0.0	0.00	4	2.7	57.45
****AI/AN Non-Hispanic**	6	4.1	8.80	5	3.4	7.34	11	7.5	16.14
*****MR/O Non-Hispanic**	0	0.0	N/A	0	0.0	N/A	0	0.0	N/A
	87	59.2	9.23	60	40.8	6.36	147	100.0	15.59
[+]MSM	30	20.4	N/A	18	12.2	N/A	48	32.7	N/A
[++]IDU	23	15.6	N/A	21	14.3	N/A	44	29.9	N/A
	14	9.5	N/A	12	8.2	N/A	26	17.7	N/A
Heterosexual	9	6.1	N/A	7	4.8	N/A	16	10.9	N/A
[+++]O/H/TF/TPR	1	0.7	N/A	1	0.7	N/A	2	1.4	N/A
[++++]NRR/UR	10	6.8	N/A	1	0.7	N/A	11	7.5	N/A
	87	59.2	9.23	60	40.8	6.36	147	100.0	15.59

* Asian Pacific/Islander/Hawaiian + Men having Sex with Men ** American Indian/Alaskan Native ++ Injection Drug Use
*** Multiple Race/Other Race +++ Other/Hemophilia/Transfusion and Blood Products/Transplant Recipient

I. HIV and AIDS by Gender, Age, Race, and Risk

1. Gender:

Table 27: HIV / AIDS CASES BY YEAR OF DIAGNOSIS AND GENDER
ARIZONA, 1981-1993 AND 1994-2004

	1981-1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
# Males	6,391	518	603	607	567	556	528	572	637	688	607	526
# Females	630	85	113	109	86	98	102	114	75	107	89	109
# Total	7,021	603	716	716	653	654	630	686	712	795	696	635

Source: Arizona Department of Health Services, Bureau of Epidemiology and Disease Control, Office of HIV/AIDS Services.

Throughout the epidemic in Arizona, the majority of emergent HIV infections have been among males, who comprise 88.2% of all confirmed emergent HIV infections, and 86.7% of current estimated prevalence. However, the proportion of female cases is increasing: for the three year period from 2002 to 2004, 12.3% of emergent cases were among women. (Integrated Epidemiologic Profile, ADHS, 2005). In 2004, 17% of the reported cases of HIV/AIDS were among women.

2. Age group:

Table 28: ARIZONA PREVALENT HIV/AIDS, EMERGENT HIV/AIDS, AND STATE POPULATION BY AGE GROUP

	Current HIV/AIDS Prevalence			Emergent HIV/AIDS 1999-2003			2003 Population Estimates	
Age	Cases	% State Total	Rate Per 100,000	Cases	% State Total	Rate Per 100,000	Population	% State Total
0-1	1	0.0%	0.56	12	0.3%	1.44	177,224	3.2%
2-12	38	0.4%	4.07	14	0.4%	0.32	932,594	16.7%
13-19	47	0.5%	8.39	52	1.5%	1.95	560,298	10.0%
20-24	171	1.7%	42.57	292	8.3%	15.52	401,734	7.2%
25-29	512	5.0%	128.58	471	13.4%	24.84	398,194	7.1%
30-34	1,021	9.9%	251.92	638	18.1%	33.29	405,283	7.3%
35-39	1,833	17.8%	475.95	722	20.5%	37.17	385,125	6.9%
40-44	2,496	24.2%	624.24	574	16.3%	29.74	399,847	7.2%
45-49	1,881	18.3%	511.51	355	10.1%	20.53	367,734	6.6%
50-54	1,146	11.1%	353.54	201	5.7%	13.07	324,147	5.8%
55-59	629	6.1%	223.51	97	2.8%	7.65	281,421	5.0%
60-64	271	2.6%	116.44	52	1.5%	4.87	232,743	4.2%
65 and Older	225	2.2%	31.49	39	1.1%	1.14	714,467	12.8%
Unknown	23	0.2%	NA	0	0.0%	N/A	N/A	N/A
TOTAL	10,294	100.0%	184.45	3,519	100.0%	13.26	5,580,811	100.0%

Source: Arizona HARS 5/1/05; NCHS 1999-2003 Bridged-Race Intercensal Estimates (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

3. Race/ethnicity:

Table 29: DISTRIBUTION OF REPORTED HIV/AIDS CASES BY YEAR OF DIAGNOSIS AND RACE/ETHNIC GROUP, ARIZONA, 1981-1993 AND 1994-2004												
Race/Ethnicity	1981-1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
White non-Hispanic	5,185	382	438	448	396	388	324	383	393	428	357	312
Black or African American non-Hispanic	586	68	61	85	46	60	72	96	91	84	87	82
Hispanic or Latino all races	955	118	181	138	177	165	192	176	180	231	212	204
Asian or Pacific Islander non-Hispanic	38	3	5	6	3	5	1	6	7	8	5	8
American Indian or Alaska Native non-Hispanic	158	27	27	33	30	33	40	24	40	42	33	29
Two or more races/ Other or unknown race	99	5	4	6	1	3	1	1	1	2	2	0
Total	7,021	603	716	716	653	654	630	686	712	795	696	635

Source: Arizona Department of Health Services, Bureau of Epidemiology and Disease Control, Office of HIV/AIDS Services

In Arizona, the HIV/AIDS epidemic primarily affects Whites and Hispanics with Blacks consistently the third ranking population most affected. A Black non-Hispanic MSM is more likely to be infected with HIV/AIDS in Arizona than any other MSM. (2005 ADHS).

4. Transmission/Exposure:

Maricopa and Pinal counties together include 77% of the state population, 88% of MSM HIV/AIDS prevalence, and 90% of MSM emergent HIV infection. Urbanization is significantly correlated with higher rates of HIV prevalence and emergence in Arizona.

Table 30: ARIZONA PREVALENT HIV/AIDS, EMERGENT HIV/AIDS, AND ESTIMATED STATE POPULATION BY COUNTY OF MSM

	Current HIV/AIDS Prevalence			Emergent HIV/AIDS 1999-2003			2003 Population Estimates	
COUNTY	MSM* Cases	% State MSM Total	Rate Per 100 MSM*	MSM* Cases	% State MSM Total	Rate Per Year Per 100 MSM*	Estimated MSM* Population	% State Total
Apache	18	0.3%	2.10	12	0.5%	0.28	859	1.2%
Cochise	64	0.9%	4.06	17	0.7%	0.22	1,575	2.2%
Coconino	68	1.0%	4.32	26	1.1%	0.33	1,575	2.2%
Gila	17	0.2%	2.64	4	0.2%	0.12	644	0.9%
Graham	14	0.2%	3.26	10	0.4%	0.47	430	0.6%
Greenlee	2	0.0%	2.78	0	0.0%	0.00	72	0.1%
La Paz	9	0.1%	4.19	2	0.1%	0.19	215	0.3%
Maricopa	4,840	69.4%	11.13	1,765	73.3%	0.81	43,467	60.7%
Mohave	108	1.5%	4.86	26	1.1%	0.23	2,220	3.1%
Navajo	29	0.4%	2.13	20	0.8%	0.29	1,361	1.9%
Pima	1,304	18.7%	11.38	402	16.7%	0.70	11,457	16.0%
Pinal	171	2.5%	6.45	72	3.0%	0.54	2,650	3.7%
Santa Cruz	23	0.3%	4.59	10	0.4%	0.40	501	0.7%
Yavapai	70	1.0%	2.96	23	1.0%	0.19	2,363	3.3%
Yuma	70	1.0%	3.15	18	0.7%	0.16	2,220	3.1%
Unknown	169	2.4%	N/A	0	0.0%	N/A	N/A	N/A
TOTAL	6,976	100%	9.74	2,407	100%	0.67	71,609	100%

*Men who have Sex with Men. Source: Arizona HARS 5/1/05; NCHS 1999-2003 Bridged-Race Intercensal Estimates; Scott D. Holmberg (1996). (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

Whites make up 68% of the State's MSM total; followed by Hispanic MSM (20.3%); Black MSM (7.3%); and American Indian MSM 3.4%. In Pinal County there are .96 MSM 'In Care' for every one MSM 'Out of Care' (with unmet need). (2005 ADHS)

Table 31: ARIZONA PREVALENT HIV/AIDS, EMERGENT HIV/AIDS, AND ESTIMATED STATE POPULATION BY COUNTY OF IDU

	Current HIV/AIDS Prevalence			Emergent HIV/AIDS 1999-2003			2003 Population Estimates	
COUNTY	**IDU* Cases**	**% State IDU Total**	**Rate Per 100 IDU***	**IDU* Cases**	**% State IDU Total**	**Est. Rate Per Year Per 100 IDU***	**Estimated IDU* Population**	**% State Total**
Apache	5	0.2%	0.70	2	0.2%	0.06	718	1.2%
Cochise	26	1.1%	1.97	4	0.5%	0.06	1,317	2.2%
Coconino	24	1.0%	1.82	6	0.8%	0.09	1,317	2.2%
Gila	7	0.3%	1.30	2	0.2%	0.07	539	0.9%
Graham	14	0.6%	3.90	10	1.3%	0.56	359	0.6%
Greenlee	0	0.0%	0.00	0	0.0%	0.00	60	0.1%
LaPaz	9	0.4%	5.00	6	0.8%	0.67	180	0.3%
Maricopa	1,445	62.4%	3.98	513	64.7%	0.28	36,331	60.7%
Mohave	61	2.6%	3.29	13	1.6%	0.14	1,856	3.1%
Navajo	9	0.4%	0.79	7	0.9%	0.12	1,137	1.9%
Pima	466	20.1%	4.87	133	16.8%	0.28	9,576	16.0%
Pinal	146	6.3%	6.59	70	8.8%	0.63	2,215	3.7%
SantaCruz	2	0.1%	0.48	2	0.2%	0.10	419	0.7%
Yavapai	34	1.5%	1.72	15	1.9%	0.15	1,975	3.3%
Yuma	25	1.1%	1.35	10	1.3%	0.11	1,856	3.1%
Unknown	46	2.0%	N/A	0	0.0%	N/A	N/A	N/A
TOTAL	2,316	100%	3.87	793	100%	0.26	59,855	100%

* Injection Drug Users. Source: Arizona HARS 5/1/05; NCHS 1999-2003 Bridged-Race Intercensal Estimates; Scott D. Holmberg (1996). (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

The majority of the State's IDU population is White (58%); followed by Hispanic IDU (21%); Black IDU (15%); and American Indian IDU (4.1%). (ADHS, 2005) Among rural counties, Pinal County has twice the proportion of prevalent IDU cases, and more than twice the proportion of emergent IDU cases as its proportion of the state population. Pinal County is also experiencing much more rapid urbanization, particularly in northern areas adjacent to metropolitan Phoenix along the I-10 corridor. The effect of urbanization may also contribute to observed elevated rates of HIV prevalence and emergence in Pinal County. (Integrated Epidemiologic Profile, ADHS, 2005)

An HIV-positive IDU is less likely to be 'In Care' than an HIV-positive MSM. For every .82 IDU 'In Care' in Pinal County, there is one IDU 'Out of Care'/with unmet need. (2005 ADHS)

c. High Risk Heterosexual

Table 32: ARIZONA PREVALENT HIV/AIDS, EMERGENT HIV/AIDS, AND ESTIMATED STATE POPULATION BY COUNTY OF HRH

	Current HIV/AIDS Prevalence			Emergent HIV/AIDS 1999-2003			2003 Population Estimates	
COUNTY	HRH* Cases	% State HRH Total	Rate Per 100 HRH*	HRH* Cases	% State HRH Total	Est. Rate Per Year Per 100 HRH*	Estimated HRH* Population	% State Total
Apache	6	0.6%	0.57	5	1.1%	0.10	1,049	1.2%
Cochise	20	1.9%	1.04	10	2.2%	0.10	1,923	2.2%
Coconino	26	2.4%	1.35	11	2.4%	0.11	1,923	2.2%
Gila	6	0.6%	0.76	1	0.2%	0.03	787	0.9%
Graham	1	0.1%	0.19	1	0.2%	0.04	524	0.6%
Greenlee	0	0.0%	0.00	0	0.0%	0.00	87	0.1%
LaPaz	3	0.3%	1.15	0	0.0%	0.00	262	0.3%
Maricopa	722	67.8%	1.36	330	71.7%	0.12	53,048	60.7%
Mohave	22	2.1%	0.81	4	0.9%	0.03	2,709	3.1%
Navajo	10	0.9%	0.60	4	0.9%	0.05	1,661	1.9%
Pima	149	14.0%	1.07	56	12.2%	0.08	13,983	16.0%
Pinal	36	3.4%	1.11	16	3.5%	0.10	3,234	3.7%
SantaCruz	4	0.4%	0.65	1	0.2%	0.03	612	0.7%
Yavapai	27	2.5%	0.94	10	2.2%	0.07	2,884	3.3%
Yuma	24	2.3%	0.89	11	2.4%	0.08	2,709	3.1%
Unknown	9	0.8%	N/A	0	0.0%	N/A	N/A	N/A
TOTAL	1065	100%	1.22	460	100%	0.11	87,395	100%

* High-risk heterosexuals. Source: Arizona HARS 5/1/05; NCHS 1999-2003 Bridged-Race Intercensal Estimates; Scott D. Holmberg (1996). (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

ADHS defines 'High Risk Heterosexual' (HRH) as "persons who themselves have no history of MSM or IDU behavior, but who have had unprotected heterosexual sex with multiple sex partners, with any partner who reports MSM or IDU behavior, or with someone who is known to be HIV infected, including persons who have had heterosexual sex with a prostitute."

Whites make up 45% of the State's total HRH population; followed by Hispanic HRH (28%); Black HRH (19%); and American Indian HRH (5.3%). Pinal County ranks third in the State for both its prevalent and emergent HRH cases. For every .89 HRH 'In Care' in Pinal County, there is one HRH 'Out of Care'. (2005 ADHS)

d. Prison Population

Table 33: Reports of HIV Infection While Incarcerated Among Prevalent HIV and Estimated Prison Populations by County

	Current County Est. HIV/AIDS Prevalence	Prevalent HIV Reported In Prison (% of Total Prevalence)	Current Estimated State/ Federal Prison Population	Reported Prison HIV/AIDS Prevalence Rate per 100,000	1999-2003 Emergent County HIV/AIDS	Emergent HIV/AIDS Reported In Prison (% of Total Emergence)
Cochise Co.	117	5 (4%)	2,178	230	32	1 (3.1%)
Graham Co.	29	13 (44.8%)	2,596	501	17	10 (58.8%)
Maricopa Co.	7010	83 (1.2%)	9,824	845	2509	84 (3.3%)
Navajo Co.	45	3 (6.7%)	1,865	161	29	2 (6.9%)
Pima Co.	1903	18 (0.9%	5,502	327	576	18 (3.1%)
Pinal Co.	331	99 (29.9%)	10,613	933	145	86 (59.3%)
Total	9435	223 (2.4%)[1]	32,578	678	3308	201 (6.1%)

1) Includes 2 cases from other counties. *Source: Arizona HARS 5/1/05; ADOC. (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

Table 34 a: RACE/ETHNICITY OF CURRENT INMATES REPORTED WITH HIV INFECTION WHILE INCARCERATED

	Reported Cases	Percentage of Reported Cases
White non-Hispanic	84	37.7%
Black non-Hispanic	45	20.2%
Hispanic	86	38.6%
Asian/Pacific Island Non-Hispanic	3	1.3%
American Indian/Alaska Native non-Hispanic	5	2.2%
Total	223	100%

*Source: Arizona HARS 5/1/05 (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

Among this incarcerated group the total proportion of persons reporting any IDU behavior is 62%, and the total number reporting any MSM behavior is 45%. This differs from the risk behavior profile of the prevalent HIV/AIDS population in the substantial increase in IDU-related HIV.

Table 34 b:REPORTED RISK BEHAVIOR ASSOCIATED WITH HIV TRANSMISSION AMONG CURRENT INMATES REPORTED WITH HIV INFECTION WHILE INCARCERATED

	Reported Cases	Percentage of Reported Cases
MSM Only	54	24.2%
IDU Only	91	40.8%
MSM And IDU	47	21.1%
Heterosexual	14	6.3%
Other Risk	3	1.3%
No Reported Risk	14	6.3%
Total	223	100.0%

*Source: Arizona HARS 5/1/05 (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

e) Hepatitis

Table 35: 2004 Cases and Case Rates of Hepatitis: Arizona and Pinal County

2004: Disease Rates per 100,000 and Number of Cases	Arizona Case Rate	AZ Cases	Pinal Case rate	Pinal Cases
Hepatitis A	4.6	267	4.1	9
Hepatitis B (acute)	5.0	289	7.3	16
Hepatitis B, Perinatal	0.0	0	0.0	0
Hepatitis C (acute)	0.0	1	0.0	0
Hepatitis D	0.0	0	0.0	0
Hepatitis E	0.0	0	0.0	0
Hepatitis Non-A Non-B	0.0	0	0.0	0

Source: Arizona Department of Health Services, Bureau of Epidemiology and Disease Control, Office of HIV/AIDS Services

Hepatitis B, characterized as the blood-borne infection more associated with poor hygiene and MSM behavior than injection drug use, was reported more frequently in Pinal County, according to 2004 case rates, than for the State as a whole.

Acute Hepatitis C, most associated with injection drug use, was not heavily reported in Pinal County or the State for 2004. The prevalence of chronic Hepatitis C is much higher (See narrative on co-infection below).

f) Sexually Transmitted Diseases

Other co-morbidities that are risk factors for transmission of HIV and also contribute to the severity of the disease are the sexually transmitted diseases. The three major STDs are chlamydia, gonorrhea and syphilis.

Table 36: 2004 STD Cases and Case Rates: Arizona and Pinal County

2004: Disease Rates per 100,000 pop and Actual Cases Sexually Transmitted	Arizona Rate/ 100,000	AZ Cases	Pinal Rate/ 100,000	Pinal Cases
Gonorrhea	70.1	4,088	99.4	217
Resistant Gonorrhea	0.0	1	0.0	0
Syphilis (primary and secondary)	2.7	160	0.0	0
Syphilis-Total	17.1	998	49.5	108
Chlamydia	289.2	16,869	219.9	480

Source: Arizona Department of Health Services, Bureau of Epidemiology and Disease Control, Office of HIV/AIDS Services

In 2004, Pinal County's case rates for gonorrhea and syphilis far exceeded the Arizona case rates. In Arizona, those diagnosed with gonorrhea are more than nine times more likely to become HIV-positive. White non-Hispanics and Hispanics account for the majority of co-infection cases of those

with gonorrhea and HIV. In Arizona, those diagnosed with syphilis are 12.5 times more likely to become infected with HIV. The majority of emergent syphilis infections are among males (ADHS 2005).

There is considerable epidemiologic synergy between HIV/AIDS and other sexually transmitted diseases, especially Hepatitis C, in Arizona. The table below evidences the high levels of co-infection and estimated odds of current HIV infection with any history of STD or Hepatitis C.

Table 37: SUMMARY COUNTS, RATES, AND ODDS OF CURRENT HIV AMONG PREVALENT PERSONS WITH ANY LIFETIME HISTORY OF HEPATITIS C INFECTION, OR INFECTION WITH ANY SEXUALLY TRANSMITTED DISEASE

Total Population:	5,580,811
Now HIV Infected with no STD or HepC Diagnosis History:	8,058
Any STD or HepC Diagnosis History but not HIV Infected:	181,466
Now HIV Infected with any STD or HepC Diagnosis History:	1,904
Estimated HIV Prevalence Rate:	179 per 100,000
Estimated Prevalence Rate of Persons with any STD or HepC Diagnosis History:	3,286 per 100,000
Estimated Prevalence Rate of HIV among Persons with any STD or HepC Diagnosis History:	1,038 per 100,000
Estimated Prevalence Rate of STD or HepC Diagnosis History among HIV Positive Persons:	19,113 per 100,000
Estimated Odds of Current HIV Infection with any History of STD or Hep C Diagnosis:	5.8 times greater

*Source: Arizona HARS 5/1/05 (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

> "ADHS Office of HIV/AIDS examined patterns of all co-morbidity reports of STDs and Hepatitis C among persons reported with HIV/AIDS. The primary modes of transmission of these reportable diseases closely correspond to those of HIV. HIV/STD/Hepatitis C co-morbidity data are direct measures of risk behavior patterns among the HIV/AIDS population, both before and after HIV diagnosis. By comparing data from Hepatitis C and four primary sexually transmitted diseases with data from HIV/AIDS, ADHS Office of HIV/AIDS program was able to find 1,904 persons believed to be now living in Arizona, who have a history of HIV infection and also have any lifetime history of diagnosis with Hepatitis C, Chlamydia, Gonorrhea, Herpes, or Syphilis. At the time that this cross-match study was completed, the prevalence of reported HIV infection in Arizona was 9,962 persons". (Integrated Epidemiologic Profile, AZDHS, 2005)

Table 38: SUMMARY COUNTS, RATES, AND ODDS OF CURRENT HIV AMONG PREVALENT PERSONS WITH ANY LIFETIME HISTORY OF REPORTED HEPATITIS C INFECTION

Total Population:	5,580,811
HIV Infected with no Hep C Diagnosis History:	8,793
HepC Diagnosis History but not HIV Infected:	54,165
HIV Infected with any HepC Diagnosis History:	1,169
Estimated HIV Prevalence Rate:	179 per 100,000
Estimated Prevalence Rate of Persons with any HepC Diagnosis History:	992 per 100,000
Estimated Prevalence Rate of HIV among Persons with any HepC Diagnosis History:	2,113 per 100,000
Estimated Prevalence Rate of HepC Diagnosis History among HIV Positive Persons:	11,735 per 100,000
Estimated Odds of Current HIV Infection with any History of HepC Diagnosis:	11.8 times greater

*Source: Arizona HARS 5/1/05 (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

"Of 1,904 persons found with HIV and any Hepatitis C or STD co-morbidity history, 1,169 (61.4%) are living with HIV and Hepatitis C. Hepatitis C infection has been reported among nearly 12% of persons living with HIV/AIDS in Arizona, and at least 2% of more than 55,000 persons known to be living with Hepatitis C are also infected with HIV. In this analysis, the odds of current HIV infection among persons with any history of Hepatitis C infection are nearly 12 times as great as those in the general population. "(Integrated Epidemiologic Profile, ADHS,2005)

Those in Arizona who have been diagnosed with an STD are 3.78 times more likely to be diagnosed with HIV than someone without an STD diagnosis. (ADHS, 2005) Men are at much greater risk than women of being diagnosed with HIV after an STD diagnosis. Men are 5.48 times more likely and women are 2.78 times more likely to be diagnosed with HIV after an STD diagnosis. (ADHS, 2005)

g) Tuberculosis – another disease, similar to Hepatitis B, that indicates poor hygiene, crowded living conditions and possibly homelessness. This disease is conjoint with HIV due to immunocompromised status.

2004:Disease Rate per 100,000 pop and Actual Number of Cases	Arizona Case rate	AZ Cases	Pinal Case rate	Pinal Cases
Pulmonary TB	4.0	227	10.7	23
Total TB	4.7	272	11.7	25

Source: Arizona Department of Health Services, Bureau of Epidemiology and Disease Control, Office of HIV/AIDS Services

The TB case rates in Pinal County are high compared to the total Arizona case rates.

III. Health Systems Disparities

Health system disparities are defined as "health conditions such as diseases, disorders and other conditions unique to, and more serious and prevalent in subpopulations in socio-economically disadvantaged and medically underserved rural and urban communities." Frequently, these subgroups equate to racial or ethnic groups (primarily Hispanic and African American) with magnification for monolingual or language disadvantaged subpopulations.

Poverty impacts life circumstances and is associated with health disparities and access to care. The rural nature of Pinal County definitely impacts access to services and results in disparities for those without independent means of transportation and/or who have inadequate transportation assistance available to them. The 'In Care' Survey Respondents report that only 10 PLWHAs (42% of ALL respondents) own their own car. The remainder of the survey sample utilize cab services, (8%); public transportation (25%); friends (13%); case managers (4%); or other means (8%) to get to HIV medical appointments. Eight respondents report getting help with transportation (35% of survey sample). Thirteen percent (13%) of all respondents report that transportation problems have kept them from getting to medical appointments. Sixty-seven percent (67%) of those having transportation difficulties report missing medical appointments 4-6 times as a result of transportation problems. Nine percent (9%) of those having difficulties report that the lack of transportation assistance has prevented them from getting to social service appointments on more than one occasion.

Table 39: DISTRIBUTION OF 'IN CARE', 'UNMET NEEDS' AND POVERTY BY COUNTY, ARIZONA 2003

	IN CARE			*UNMET NEEDS*			Ratio	*2002 POVERTY*	
COUNTY	**CASES**	**%**	**Rate Per 100,000**	**CASES**	**%**	**Rate Per 100,000**	**'In Care' /'Unmet Needs'**	**Number of Persons**	**% of County Pop.**
APACHE	12	0.2	17.65	13	0.3	19.12	0.92	25,798	37.8
COCHISE	48	1.0	39.85	73	1.5	60.61	0.66	19,772	17.7
COCONINO	46	1.0	38.24	66	1.3	54.87	0.70	20,609	18.2
GILA	15	0.3	29.09	9	0.2	17.45	1.67	8,752	17.4
GRAHAM	6	0.1	18.10	23	0.5	69.40	0.26	6,952	23.0
GREENLEE	2	0.0	25.55	1	0.0	12.77	2.00	842	9.9
LA PAZ	5	0.1	25.62	13	0.3	66.61	0.38	3,798	19.6
MARICOPA	3524	72.9	106.66	3242	66.4	98.13	1.09	355,668	11.7
MOHAVE	62	1.3	37.44	109	2.2	65.82	0.57	21,252	13.9
NAVAJO	24	0.5	23.48	15	0.3	14.68	1.60	28,054	29.5
PIMA	864	17.9	98.05	975	20.0	110.64	0.89	120,778	14.7
PINAL	115	2.4	58.59	170	3.5	86.61	0.68	27,816	16.9
SANTA CRUZ	15	0.3	37.47	14	0.3	34.97	1.07	9,356	24.5
YAVAPAI	58	1.2	32.39	66	1.3	36.86	0.88	19,552	11.9
YUMA	41	0.8	24.49	75	1.5	44.80	0.55	29,670	19.0
UNKNOWN	0	0.0	N/A	18	0.4	N/A	N/A	N/A	N/A
TOTAL	**4837**	**100**	**88.65**	**4882**	**100**	**89.47**	**0.99**	**698,669**	**13.9**

Source: Arizona HARS 8/6/04; Census 2000. (Adapted from Integrated Epidemiologic Profile, ADHS, 2005)

As a whole, for every <u>0.68</u> person infected with HIV in Pinal County who is 'In Care', there is <u>one</u> HIV-positive person with unmet needs. This finding emphasizes the need to examine the 'Out of Care' population, to determine how those persons not in care may be assisted in entering and/or returning to care and treatment.

Disparities in health are also defined as unequal burdens in disease morbidity and mortality rates experienced by ethnic/racial groups as compared to the dominant group. (USDHHS, 2000) HIV/AIDS for Blacks in the U.S. is more than 7 times that for Whites. (Surgeon general, 2001) In 2000, the incidence of adult and adolescent AIDS cases per 100,000 was 74.2 for Non-Hispanic Blacks; 30.4 for Hispanics; compared to 7.9 for White Americans. (CDC MMWR 2001)

Non-Hispanic Blacks are highly disproportionately impacted by HIV and AIDS in Pinal County, as evidenced by the great differences in case rates among the racial/ethnic populations represented. ***Of the living cases of HIV/AIDS in Pinal County, Non-Hispanic Blacks have a case rate of 493.18 compared to Asian/Pacific Islanders (294.46); Hispanics (228.20); American Indians (130.04); and Whites (107.09).***

Chapter 3 In Care Findings[6]

1. Introduction

A comprehensive assessment of the service needs of persons living with HIV/AIDS (PLWHA) and residing in Pinal County within the Phoenix EMA, was conducted in January through March of 2006. This four-part assessment of need included:

1. 'In Care' written survey questionnaires of persons receiving Ryan White funded services utilizing the Needs Assessment Client Survey (NACS) tool;
2. 'In Care' telephone survey questionnaires of rural residents receiving Ryan White funded services utilizing the Needs Assessment Client Survey (NACS) tool;
3. 'In Care' written survey questionnaire of Incarcerated persons receiving Prison Health Services utilizing the Needs Assessment Client Survey (NACS) Tool; and
4. "Out of Care" telephone surveys of persons living with HIV/AIDS, but NOT receiving HIV services over the past year (*see Chapter 4 for a complete discussion of findings*).

The main objective of the 2006 Needs Assessment process was to provide the data necessary to inform decisions relating to the Phoenix EMA Planning Council's prioritization of care services for the Ryan White CARE Act's Title I funding allocation process. Additional goals of the project were to:

- Assess the current continuum of care in Pinal County; and to determine, what, if any health care disparities exist with the County's/EMA's continuum of care;
- Determine what barriers to care exist for those individuals who know their HIV status and are not accessing primary medical care (Unmet Need);
- Provide legislatively mandated information to the federal Health Resources Services Administration (HRSA) on service needs and system response; and
- Provide planning information for agencies, organizations, and health care providers.

The 2006 HIV/AIDS Needs Assessment provides a "snapshot" of the PLWHA community service needs, usage, barriers, and gaps as expressed by consumers of HIV related services. By nature, the needs assessment process must be ongoing to reflect the changing nature of the consumer base, service delivery system, treatment advances and epidemic trends. To that end, a comparison between the needs assessment findings of the Community 'In Care', Incarcerated 'In Care', and the 'Out of Care' Survey Respondents is presented in Chapter 5, and may serve as a baseline for future needs assessment studies.

Using Arizona Department of Health HARS (HIV & AIDS Reporting System) data, the number of persons living with HIV/AIDS in Pinal County was determined to be 331 (2005 Integrated Epidemiologic Profile). Approximately 30% of these prevalent HIV/AIDS cases (N=99) reside in the prison setting in Pinal County. Based upon the State's 'unmet need' data, the total number of unduplicated PLWHA receiving Ryan White funded services ('In Care/In System') is currently estimated to be 115. The estimated number of PLWHA receiving primary care services funded through other third party payors (defined as 'In Care/Out of System') is currently unknown. The remaining 170

[6] In Care – defined by HRSA as receiving one or more of the following services 1) Viral Load test 2) CD4 Cell Count and/or 3) Antiretroviral drugs within the past 12 months

PLWHA are considered 'Out Of Care'. The following table provides a care status breakdown for the total PLWHA within Pinal County.

In Care Status of Pinal County PLWHAs

Care Status	In Care Ryan White	In Care non Ryan White	Out of Care	Total PLWHA
Client Count	**115***	**?**	**170**	**331***
Facility	**McDowell and other RW funded providers**	**Medicare, Private Insurance, Prison Service**	**No CD4, Viral Load, ART in the past 12 months**	

**ADHS 2003 Unmet Needs Data and 2005 Integrated Epidemiologic Profile*

The goal of the 'In Care' survey process was to achieve a 25-30% participation rate by the 'In Care/In System' clients, hereafter referred to as 'In Care' population (N=28-35). The actual 'In Care' participation rate was 26% (N=30). This level of participation represents a baseline for future assessments of need for the County. Because there is such a significant HIV positive prison population in Pinal County, a separate 'In Care' survey of the affected prison inmates was deemed essential to the integrity of the needs assessment process. Therefore, a 15% target for In Care/Incarcerated Survey Respondents (Total N= 99) was set, with a goal of surveying at least 15 Inmates. A total of 16 HIV-positive Inmates actually participated in the Incarcerated 'In Care' survey process.

5. Methodology

a. In Care Survey Sample

The sample for surveying the 'In Care' population was first determined by establishing a goal of 25-30% participation from the number of PLWHA receiving Ryan White funded primary care services. The Arizona Department of Health Services estimates that as of December 31, 2003, there were a total of 331 persons living with HIV/AIDS in the Pinal County service area of the Phoenix Title I EMA. Current Ryan White primary care providers report serving a total of 115 unduplicated persons. Therefore, the 25-30% target for 'In Care' Survey Respondents was set at 28-35 persons. A target sample set by demographic and risk profile was used to establish an accurate means of matching survey participants to this dataset in order to reflect the total 'In Care' population. An additional 15% target for In Care/Incarcerated Survey Respondents (Total N= 99) was set, with a goal of surveying at least 15 Inmates.

b. Survey Sites

The 'In Care' survey process was implemented under the direction of Collaborative Research. The survey site for the 'community-based' survey process included the Ryan White funded Case Management service provider agency, in order to access those persons currently receiving RW funded services and to *ensure a minimum of duplication* among survey participants. Because the targeted survey participants are residing in geographically diverse locations and are known to have difficulties with transportation assistance, an alternative telephone survey process via a 1-800 number was made available, in addition to the use of in-person written surveys. The survey sites for the 'Incarcerated In Care' respondents within the Prison included: ADC-North Unit; ADC-JAJC; and ADC-Meadows.

Survey Respondents received a $20 Safeway or Wal-Mart food card for participating in the survey process.

Overview of 'In Care' Survey Results

The 'In Care' client surveys were scheduled over a two-month period in January/February of 2006, with 46 total surveys completed. The table below indicates the ethnicity/race, gender and risk characteristics of the 'In Care' survey population. Thirty (30) of the 'In Care' respondents represent community residents of Pinal County who are receiving Ryan White funded services. Sixteen (16) of the 'In Care' survey sample include incarcerated persons in care. The table on the following page demonstrates client representation by the following Severe Need Groups.

The needs assessment findings will be discussed in two sections: first, the Community 'In Care' survey findings will be presented, followed by the Prison 'In Care' findings.

Table 40: 2006 Total 'In Care' Client Respondent Profile: Inclusive of both Community and Incarcerated 'In Care' populations (N=46)

Pinal-Phoenix County 2006 NA Target Sample Sets*	***Target***	***Actual***
Race/Ethnicity		
Black, not Hispanic		9
White, not Hispanic		24
Hispanic		9
American Indian, not Hispanic		1
Other		3
Not Specified		
Total		***46***
Gender		
Male		37
Female		6
Prefer not to Answer		3
Transgender		0
Total		***46***
Exposure Category		
MMS		16
Injection drug use (IDU)		6
Men who have sex with men and inject drugs (MMS + IDU)		1
FMS		16
Pediatric		1
Transfusion/Hemophiliac		2
Other		3
Not classified		1
Total		***46***

I. COMMUNITY 'In Care' Needs Assessment Survey Findings

Table 41: 2006 Community 'In Care' Severe Need Groups

Severe Need Group	#	%
AA MSM	2	6%
Anglo MSM	7	23%
His MSM	4	13%
High Risk HET	10	33%
WCB	5	16%
IDU	3	10%
TOTAL	**30**	**100%**

LEGEND:

AA MSM	**African American MSM**
Anglo MSM	**Caucasian MSM**
API MSM	**Asian Pacific Islander APM**
HIS MSM	**Hispanic MSM**
High Risk HET	**High Risk Heterosexuals**
WCB	**Women of Childbearing Age (15-44 years)**
IRR	**Incarcerated/ Recently Released**
SA	**Substance Abuser**
IDU	**Injection Drug User**

Demographic and Health Profile of ALL Community 'In Care' Survey Respondents:

Demographic representation by the 30 'In Care" Community Survey Respondents was consistent with those of the affected community:

- 70% (or 21) of all respondents were Male; 20% (or 6) were Female; and 10% (3) preferred not to answer, reflective of the epidemiologic profile;
- 33% (or 10) of all respondents identify their transmission risk as High Risk Heterosexual; 42% (or 13) as Homosexual/Gay men; and 10% (or 3) as IDU; 6% (or 2) transfusion-related; and 3% (1) as Mother with HIV/AIDS;
- The majority of respondents were in the 35-54 age range;
- 63% of respondents were Caucasian (19); 17% were Hispanic (5); 10% of respondents were African American (3); 10% identified as "Other Race" (3).
- Representation by Severe Need Group includes the following:10 Heterosexuals; 7 Anglo MSM; 3 Hispanic MSM; 1 African American MSM; 5 Women of Childbearing Age; and 3 IDU.

Demographic and Risk Profile of 'In Care' Severe Need Group Respondents (other than African American MSM, Anglo MSM and Hispanic MSM, for whom the groupings are self-explanatory)*:*

Table 42: 2006 Demographic/Risk Profile of Community In Care SNG Client Respondents

Severe Need Group/Sub-Set of Severe Need Group	Gender, Race/Ethnicity of SNG Members
Intravenous Drug Users (IDU): 3 'In Care' Respondents	3 Males; 2 White; 1 Hispanic
Women of Childbearing Age (WCB): 5 Female 'In Care' Respondents	5 Females 4 White; 1 Hispanic
High Risk Heterosexuals: 10'In Care' Respondents	5 Males; 5 Females 8 White; 2 Hispanic

Residence and Living Arrangements

Eighty- two percent (82%) of all respondents reside in the following counties: Apache Junction (30%), Arizona City (20%), Casa Grande (13%); Coolidge (7%), or Eloy (7%). The remaining 23% reside in Florence (3%), Queen Creek (7%), Mammoth (10%), or San Manuel (3%). The majority of the respondents (57%) live with an adult friend/relative. Almost one-third of the 'In Care' respondents (8 or 27%) now live in a house they own and another 13% live in a rented home/apartment. Fourteen persons (47%) report living with a friend or relative. None of the 'In Care' survey sample is currently homeless. None reported having been in prison or jail in the past six months (though four persons preferred not to answer this question). Three respondents (10%) report having been homeless in the previous two years, but not now. Twenty percent (20% or 5 persons) were homeless over two years ago for a period of time, but not now.

HIV/AIDS Status-Respondents and Household Members

Sixty-three percent (63%) of all respondents reported living with HIV, while 30% reported an AIDS diagnosis. (Two persons did not report their HIV status.) Two respondents report living with someone who is also HIV positive. ***Fifty-seven percent of the Community 'In Care' survey sample (17 of 30 persons) report their HIV diagnosis was established in another state, evidencing the extent of migration into the Phoenix area.***

'In Care' Respondent Testing/Linkages and Time to Care

Initial reasons supplied for being tested for HIV by 43% of all respondents was "I was sick": (10 respondents), followed by "My partner told me to" (4 respondents or 13%); "Admission to hospital/tested there" (2 respondents or 7%); and "Partner notification services" (one respondent or 3%). Additional reasons cited by 17% of all respondents included: testing in prison (7%), testing upon blood donation (3%); doctor suggested testing (3%), and suspected that partner was infected (3%). Thirty-three percent (33%) report their initial HIV testing was conducted in a hospital or ER setting; 20% in a Doctor's office; and only 13% at an HIV C/T site.

Upon learning their sero-status at the time of their HIV diagnosis, only one third (or 35%) of the 'In Care' respondents report being referred into HIV medical care. Eleven respondents (35%) report immediate entry into HIV medical care within 1 to 3 months of diagnosis.

Seven respondents (23%) delayed entering HIV medical care for over one year. (Nine respondents preferred not to answer this question, so that the exact delay into care statistic is unknown.)

The major reasons supplied for the delay into medical care and treatment included "denial" and 'other' (including 'homeless', lack of effective medicine available at time of diagnosis, no specialist available)**.**

Table 43: Reasons Prompting Medical Care for HIV Disease

MOTIVATION	#	%
Admitted to Hospital	1	3%
Got Real	1	3%
Scared Not To	2	7%
Other	4	14%
Preferred Not to Answer	22	73%
TOTAL	**30**	**100%**

Table 44: Perceived Aids to Ease Entry Into Care Earlier

MOTIVATION	#	%
Talk/Counseling about HIV when I was first diagnosed	1	3%
Someone with HIV to help me with the shock of a positive diagnosis	2	7%
A tougher approach to the drawbacks of not receiving medical care for HIV	2	7%
Preferred Not to Answer	25	83%
TOTAL	**30**	**100%**

Twenty-eight of 30 respondents report seeing their Doctor to treat their HIV disease within the past four months or less, however only 25 persons (83%) of the Community 'In Care' survey sample reports having had a CD4 cell count or viral load lab test drawn over the past year.

Educational Level and Employment Status

Seventeen percent (17%) of all respondents finished high school or completed a GED; another 10% had some high school or grade school education; 30% of respondents have had some college education and four respondents (13%) hold a college degree.

The majority of all respondents (67%) are NOT employed. Because 78% of the survey sample reports having Medicare or Medicaid benefits, of those not working, disability may be the reason. Four persons (or 13%) of all respondents are employed, either working full-time or part-time. Twenty percent of the survey respondents preferred not to answer this question.

Income Level, Health Insurance and Benefits

The majority of all respondents (N=21 of 30 total) report annual income levels at or below 200% of the federal poverty level, with 11 of those persons living at or below the 100% FPL.

The vast majority of all 'In Care' respondents also report having some form of health insurance benefit (including 33% or 10 respondents with Medicare; 46% or 14 respondents with Medicaid; and 7% or 2 persons with private insurance). Two persons (7%) report Delta Dental coverage. *Only one respondent reported having no form of health insurance coverage.*

HIV Primary Care Locations

Twenty-five of 30 respondents report receiving a CD4 cell count and/or viral load test in the previous 12 months. Thirty-seven percent (37%) of all respondents report receiving their HIV medical services at McDowell; three persons (10%) access their HIV primary care services at Spectrum; two persons report accessing HIV care at Pueblo Scottsdale or Pueblo Phoenix, respectively; and one person receives their HIV primary care at Sun Life Family Health Center. 41% (11 persons) receive their HIV primary care services through a variety of other Physicians, including Drs. Coolidge, Estok, Guidia, Piatt, Frist, Fisher, and Robinson. *Only seven persons (23% of the survey sample) report seeing a dentist over the past year; two of whom required extractions.*

Co-Morbidities

The Pinal 'In Care' population reports multiple co-morbidities. Thirty percent (30%) of all respondents report multiple other physical health conditions and the majority reports at least one other medical condition, in addition to HIV disease, including 21% Hepatitis (with a history of Hepatitis A, B, or C); 11% cardiac conditions; 16% nerve conditions; 8% hypertension; 8% Diabetes; 11% other physical ailments such as a blood clotting disorder, high cholesterol or bursitis); and 5% cancers (one cervical cancer and one non-Hodgkins lymphoma).

The Pinal 'In Care' population also reports a high level of mental health disorders: 37% report depression, a mood disorder, bipolar disorder, schizophrenia, or manic depression. Eight persons report having mental health treatment recommended to them and seven respondents have received some form of mental health care. Most respondents who have received mental health treatment report receiving long-term treatment for many years. Six respondents are currently seeking mental health treatment.

Substance Use

A total of four respondents (13%) admit to a history of IDU, including the intravenous use of cocaine, crystal methamphetamine, heroin and 'speedball'. Two of these four respondents admit to having shared needles and/or drug paraphernalia with others. Seventeen percent (17%) of all respondents admit to current use of non-IV drug substances, including crystal methamphetamine (2 persons); oxycontin and valium (2 persons); cocaine (1 person); and alcohol (1 one person). *Only one respondent admitted to having sex while using drugs or alcohol (27 persons or 90% of the survey sample preferred not to answer this question).*

Sexual Activity and Risk

Only seven respondents admitted to current sexual activity within the past six months. (Eighteen stated they had <u>not</u> engaged in sexual activity and 5 persons preferred not to answer the question.) Only one person (of the seven respondents to this set of questions) responded to the question regarding number of sexual partners. This individual admitting to having had six sexual partners in the past six months.

Condom use over the past six months yielded the following answers: three respondents state they ALWAYS use condoms for <u>vaginal</u> sex; one NEVER uses condoms for <u>vaginal</u> sex; two ALWAYS use condoms for <u>anal</u> sex; one SOMETIMES uses condoms for <u>anal</u> sex.

With regard to *casual sex*, only one respondent reported sexual activity with casual partners. This same respondent reports sex with their main MSM partner after the casual partner without disclosing the

casual sex. This individual reports that this is always the case, when responding to the question "How often?" One respondent reports they feel "they have to have sex"; two respondents report using the internet to locate casual sex partners. Two respondents admit to having sex without condoms since their HIV diagnosis "all the time".

Three respondents report affirmatively having ever paid someone for sex; none of the respondents to this question admit to ever having sex for money, drugs, rent, etc. Four respondents report ever having been a victim of domestic violence; five respondents report ever having been a victim of sexual assault.

Sexually Transmitted Diseases (STDs)

Ten respondents (of 30 total) report a history of STDs and 14 deny a history of sexually transmitted disease. (Six persons preferred not to answer this question.) Reported STDs include: Chlamydia (9%); Gonorrhea (18%); Syphilis (9%); Venereal Warts (18%); and Herpes (36%). *Only one respondent reported having had an STD diagnosed within the past year*.

The 'In Care' Needs Assessment Survey results are discussed in order by the frequency and rankings of expressed service needs, service usage, service gaps and service barriers based upon the following definitions:

NEED:	Rank order of need frequency among Service Categories *(1 is highest NEED rank)*
USE:	Rank order of use among Service Categories *(1 is highest USE rank)*
GAP:	Rank order among Respondents who indicated NEED and NO ACCESS to this Service Category *(1 is highest GAP rank)*
BARRIER:	Rank order among Respondents who indicated NEED and HARD TO ACCESS this Service Category (*1 is highest BARRIER rank)*

The top ranked NEEDS for the Community 'In Care' population by ALL respondents were:

Table 45: Service NEEDS: ALL Community 'In Care' Respondents

Service Category Description	Need Freq	Need Frequency	Need Rank
AMBULATORY OUTPATIENT MEDICAL CARE	25	83%	1
HOUSING ASSISTANCE	14	47%	2
ORAL HEALTH -DENTAL	12	40%	3
DRUG REIMBURSEMENT PROGRAM	9	30%	4
CASE MANAGEMENT	5	17%	5
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	3	10%	6
SPECIALTY MEDICAL CARE	2	7%	7
TRANSPORTATION	2	7%	7

Table 46: Top Priority Service NEEDS by Severe Needs Groups

Anglo MSM	AA MSM	HIS MSM	High Risk HET	WCB	IDU
#1 Ambulatory Medical Care	#1 Ambulatory Medical Care	#1 Ambulatory Medical Care	#1 Ambulatory Medical Care	#1 Ambulatory Medical Care Oral Health**	#1 Ambulatory Medical Care Housing Assistance Oral Health**
#2 Transportation Housing Assistance**	#2 Oral Health Food Bank Housing Assistance Transportation Mental Health**	#2 Oral Health	#2 Drug Reimbursement	#2 Housing Assistance	#2 Psychosocial Support Specialty Medical Care**
#3 Oral Health Job placement Case Management**	*	#3 Buddy/Companion Emergency Financial Assistance Specialty Medical Care**	#3 Oral Health	#3 Transportation	*
#4 Drug Reimbursement Mental Health**	*	*	#4 Case Management	#4 Case Management Food Bank Support Groups**	*
*	*	*	#5 Food Bank Housing Related Assistance Housing Assistance**	*	*

***Indicates no further service rankings offered** ** ** Indicates service ranking tie*

Among the Severe Need Groups, when asked to rank top priority NEEDS, there is great consistency in identifying Ambulatory Medical Care as the top priority NEED, followed by Oral Health, Housing Assistance, Food Bank Services, Transportation, Mental Health/Support Groups, Specialty Medical Care and Medications as priority NEEDS.

When asked "As a person living with HIV/AIDS what are the top 5 NEEDS", Respondents listed the following services as the 5 most important needs:

SERVICES	#	%
PRIMARY MEDICAL CARE	18	60%
DENTAL CARE	8	21%
MEDICATIONS	5	17%
TRANSPORT TO DOCTOR	5	17%
HOUSING	5	17%
SUPPORT GROUPS	4	13%
MENTAL HEALTH COUNSELING	3	10%
FINANCIAL ASSISTANCE	2	7%
FOOD BANKS, HOME DELIVERED MEALS	2	7%
JOB PLACEMENT	2	7%
HIV EDUCATION	1	3%
SPECIALTY MEDICAL CARE	1	3%
BUDDY / COMPANION	1	3%
CO-PAY FOR INSURANCE	1	3%
PREFER NOT TO ANSWER	2	7%
TOTAL	**60**	**100%**

There is great consistency among the answers to the two NEEDS assessment queries between ALL Community 'In Care Respondents and those of the Severe Need Groups. This evidences high internal consistency between survey responses to questions pertaining to top priority NEEDS, whether survey participants are asked to rank their top priority service needs or whether asked to list their top service needs. It also evidences a high level of consistency in responses between the entire Community survey sample and the Severe Need Groups, demonstrating a high level of homogeneity in perceptions of priority service needs among all populations in care.

The 2006 Pinal County NEEDS Matrix on the following page compares the NEEDS rankings by ALL Respondents versus NEEDS Rankings by each SNG:

2006 PINAL COUNTY NEEDS MATRIX	ALL N=30		SEVERE	NEED	GROUPS		
Service Category	**2006 A Rank (N=30)**	**Anglo MSM (N=7)**	**AA MSM (N=2)**	**HIS MSM (N=4)**	**High Risk HET (N=10)**	**WCB (N=5)**	**IDU (N=3)**
Ambulatory Outpatient Medical Care	**1**	1	1	1	1	1	1
Housing Assistance	**2**	2	2	*	5	2	1
Oral Health	**3**	3	2	2	3	1	1
Drug Reimbursement Program	**4**	4	*	2	2	*	*
Case Management	**5**	3	*	*	4	4	*
Food Bank Services	**6**	*	2	*	5	4	*
Transportation	**7**	2	2	*	*	3	*
Specialty Medical Care	**7**	*	*	3	*	*	2
Buddy/Companion Services	**8**	*	*	3	*	*	*
Housing Related Services	**8**	*	*	*	5	*	*
Mental Health	**8**	4	2	*	*	*	*
Psychosocial Support	**8**	*	*	*	*	*	2
Support Groups	**8**	*	*	*	*	4	*
Emergency Financial Assistance	**8**	*	*	3	*	*	*
Job Placement	*****	3	*	2	*	*	*

As strikingly evident when viewed in the above comparison table, Ambulatory Medical Care is consistently ranked as the #1 service priority NEED by the entire group of 'In Care' respondents as well as by all the Severe Need Groups. There is also substantial consistency among all populations regarding the multiple #2 ranked priority NEEDS, including: Housing Assistance, Oral health, and Drug Reimbursement Program. Case Management, Food Bank, and Transportation also receive high rankings as priority service needs.

The top 14 highest ranking NEEDED and USED services by ALL Community 'In Care' respondents are *identical, except for Housing Assistance, which ranks as a high priority need, but low use ranking (further explained below under GAP section). Both Support Groups and Emergency Financial Assistance are also identified as service gaps and barriers, as discussed below.*

Table 47: Service NEEDS Compared to Services USES: ALL Respondents

Service Category Description	Need Freq	Need Frequency	Need Rank	Use Freq	Use Frequency	Use Rank
AMBULATORY OUTPATIENT MEDICAL CARE	25	83%	1	11	37%	1
HOUSING ASSISTANCE	14	47%	3	0	0%	8
ORAL HEALTH -DENTAL	12	40%	2	8	27%	2
DRUG REIMBURSEMENT PROGRAM	9	30%	4	7	23%	3
CASE MANAGEMENT	5	17%	5	5	1%	4
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	3	10%	6	2	7%	6
SPECIALTY MEDICAL CARE	2	7%	7	2	7%	6
TRANSPORTATION	2	7%	7	3	10%	5
BUDDY/COMPANION	1	3%	8	1	3%	7
EMERGENCY FINANCIAL ASSISTANCE	1	3%	8	0	0%	8
HOUSING RELATED SERVICES	1	3%	8	1	3%	7
MENTAL HEALTH	1	3%	8	1	3%	7
PSYCHOSOCIAL SUPPORT	1	3%	8	1	3%	7
SUPPORT GROUPS	1	3%	8	0	0%	8

As another means of documenting service USE, Respondents were asked to "List the top 5 services you use to stay in care for HIV".

Table 48: Top 5 Service USES: ALL Community 'In Care' Respondents

SERVICES	#	%
PRIMARY MEDICAL CARE	12	40%
MEDICATIONS	7	23%
DENTAL CARE	7	23%
CASE MANAGEMENT	5	17%
TRANSPORT TO DOCTOR	4	14%
SPECIALTY MEDICAL CARE	2	7%
FOOD BANK, HOME DELIVERED MEALS	2	7%
SOCIAL SERVICES	1	3%
ALTERNATIVE THERAPIES	1	3%
MENTAL HEALTH COUNSELING	1	3%
BUDDY COMPANION	1	3%
NUTRITIONAL SUPPLEMENTS	1	3%
CLEANING	1	3%
TOTAL	**45**	**100%**

The top ten ranked <u>GAPS</u> in services needed but perceived as inaccessible for ALL respondents, evidenced in the table below, were:

1. *Specialty Medical Care*
2. *Vision Care*
3. *Food Bank*
4. *Support Groups*
5. *Dental Care*
6. *Housing Assistance*
7. *Emergency Financial Assistance*
8. *Job Placement*
9. *Alternative Therapies*
10. *Rural Access*

Table 49: Top 5 Service GAPS: ALL Community 'In Care' Respondents

Service Category Description	Gap Freq	Gap Frequency	Gap Rank
HOUSING ASSISTANCE	1	3%	6
ORAL HEALTH -DENTAL	2	7%	5
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	5	17%	3
SPECIALTY MEDICAL CARE	10	33%	1
EMERGENCY FINANCIAL ASSISTANCE	1	3%	6
SUPPORT GROUPS	4	13%	4
ALTERNATIVE THERAPIES	1	3%	6
JOB PLACEMENT	1	3%	6
RURAL ACCESS	1	3%	6
VISION CARE	7	23%	2

Table 50: Top Priority Service GAPS by Community 'In Care' Severe Needs Groups

Anglo MSM	AA MSM	HIS MSM	HET	WCB	IDU
#1 Job Placement	#1 Food Bank	#1 Support Groups	#1 Specialty Medical	#1 Housing Assistance	#1 Support Groups
#1 Vision Care**	#1 Support Groups**	#2 Alternative Therapies	#2 Emergency Financial Assistance	#1 Nutrition Counseling**	#2 Emergency Financial Assistance
*	*	#3 Emergency Financial Assistance	#3 Drug Reimbursement Program	*	#2 Specialty Medical**
*	*	*	#4 Nutrition Counseling**	*	*
*	*	*	#4 Vision Care**	*	*

Indicates no further service rankings offered** * Indicates service ranking tie***

There is a high level of consistency among all of the Severe Need Groups as to perceived GAPS. *Support groups, Emergency Financial Assistance, Nutrition Counseling, and Vision Care are all ranked as priority service GAPS, perceived as 'unavailable' by two or more SNGs.*

The top three ranked BARRIERS to needed services that are perceived as <u>hardest to access</u> by <u>ALL</u> respondents and would prevent the 'In Care' from remaining in care are:

- **Transportation**
- **Rural Access**
- **Emergency Financial Assistance**

While ALL the survey respondents as a whole only ranked three services as BARRIERS in this section of the survey, *two of the top three ranking service <u>BARRIERS</u> (Rural Access and Emergency Financial Assistance) also represent some of the highest ranking service <u>NEEDS</u> and service <u>GAPS</u> by the entire population of 'In Care' survey respondents.*

Table 51: 2006 Highest Ranking BARRIERS for all Community 'In Care' Severe Need Groups

Anglo MSM	AA MSM	HIS MSM	HET	WCB	IDU
#1 Food Bank	#1 Ambulatory Medical Care	#1 Ambulatory Medical Care	#1 Transportation	#1 Food Bank	#1 Transportation
#2 Transportation	#1 Food Bank	#1 Support Groups	#2 Rural Access	#2 Transportation	#1 Food Bank
#3 Early Intervention	#1 Transportation	#1 Food Bank	#3 Early Intervention	#3 Ambulatory Medical Care	#1 Rural Access
#3 Rural Access	#1 Rural Access	#1 Rural Access	*	#4 Rural Access	#2 Early Intervention

Indicates no further service rankings offered

It is concerning that Primary Care/Early Intervention Services, Rural Access, Transportation, Food Bank, and Early Intervention are consistently noted by a majority of the SNGs as 'hard to access'.

When ALL respondents were later asked to list "The top 5 services that you need for HIV that are hard to get", the following services were cited as barriers, indicating these services are perceived as difficult to access:

Table 52: Top Priority Service BARRIERS cited by ALL Community 'In Care' Respondents

SERVICES	#	%
TRANSPORTATION	8	31%
DENTAL CARE	6	23%
MEDICATIONS	3	12%
HOUSING	2	7%
SPECIALTY MEDICAL CARE	2	7%
FINANCIAL ASSISTANCE	1	3%
CLEANING	1	3%
SUPPORT GROUPS	1	3%
MENTAL HEALTH COUNSELING	1	3%
FOOD BANK	1	3%
TOTAL	**26**	**100%**

When ALL Respondents were asked to supply perceived reasons for barriers: ("Why are these services hard to get?"), rural location and transportation were cited again as major impediments to needed services:

Table 53: Reasons for BARRIERS cited by ALL Community 'In Care' Respondents

Barrier Explanations	#	%
RURAL LOCATION-NOT EASILY ACCESSIBLE	9	30%
TRANSPORTATION	8	27%
ELIGIBILITY REQUIREMENTS	1	3%
PAPERWORK	2	7%
COST	1	3%
Totals	**21**	**100%**

When ALL Respondents were asked to cite the services needed that are perceived as inaccessible to them ("List the top 5 services that you need for HIV that you can't get"), the following services were cited as unavailable:

Table 54: Services Viewed as Unavailable cited by ALL Community 'In Care' Respondents

SERVICES	#	%
SUPPORT GROUP	3	10%
VISION CARE	3	10%
DENTAL	2	7%
SPECIALTY MEDICAL CARE	2	7%
RURAL ACCESS	1	3%
DIABETIC ASSISTANCE	1	3%
ALTERNATIVE THERAPIES	1	3%
HOUSING	1	3%
FINANCIAL ASSISTANCE	1	3%
JOBS	1	3%
FOOD BANK	1	3%
TOTAL	**17**	**100%**

The major reason cited by Respondents for the perceived unavailability of certain services, ("Why can't you get these services?), was <u>rural location</u>:

Table 55: Reasons Why Services Unavailable as Perceived by ALL Community 'In Care' Respondents

Reason	#	%
RURAL LOCATION	10	33%
SERVICE REIMBURSEMENT DISCONTINUED	1	3%
INSURANCE	1	3%
INCOME ABOVE REQUIREMENT	1	3%
TOTAL	**13**	**100%**

II. INCARCERATED Population of 'In Care' Survey Respondents

Table 56: 2006 Incarcerated 'In Care' Profile by Severe Need Groups

Severe Need Group	#	%
AA MSM	2	6%
Anglo MSM	1	23%
High Risk HET	9	33%
IDU	4	10%
IRR TOTAL	**16**	**100%**

LEGEND:

AA MSM	**African American MSM**
Anglo MSM	**Caucasian MSM**
API MSM	**Asian Pacific Islander APM**
HIS MSM	**Hispanic MSM**
High Risk HET	**High Risk Heterosexuals**
WCB	**Women of Childbearing Age (15-44 years)**
IRR	**Incarcerated/ Recently Released**
SA	**Substance Abuser**
IDU	**Injection Drug User**

Demographic and Health Profile of ALL Incarcerated 'In Care' Survey Respondents:

Demographic representation by the 16 'In Care" Incarcerated Survey Respondents was consistent with those of the affected community:

- 100% (or 16) of all respondents were Male; reflective of the IRR profile;
- 56% (or 9) of all respondents identify their transmission risk as Heterosexual; 19% (or 3) as Homosexual/Gay men; and 25% (or 4) as IDU;
- The majority of respondents (93%) were in the 25-54 age range;
- 31% of respondents were Caucasian (5); 25% were Hispanic (4); 38% of respondents were African American (6); 6% identified as American Indian (1).
- Representation by Severe Need Group includes the following: 9 Heterosexuals; 1 Anglo MSM; 2 African American MSM; and 4 IDU.

Residence and Living Arrangements

All of the IRR 'In Care' population consider themselves "homeless"; three persons report having been homeless in the past two years. Obviously, all of the incarcerated sample report current residence in the prison setting. Five of the IRR respondents report having been in jail or prison more than two years ago.

Upon release from prison, three respondents (19%) plan to reside at the CASS Shelter; four persons plan to reside with a relative (25%); four persons plan to gain shelter through Shanti; one person plans to reside in Phoenix, and one person plans on living in Tucson; while three persons (19%) state they don't know where they will be living upon exit from the penal system.

HIV/AIDS Status---Respondents and Household Members

Seventy-five percent (75%) of all respondents (N=12) reported living with HIV, while 25% reported an AIDS diagnosis (N=4). Fifty-eight percent of the IRR 'In Care' survey sample (7 of 12 persons) report their HIV diagnosis was established since the year 2000, evidencing an 'earlier' to care proportion among the IRR, as compared to the Community group, perhaps attributable to the fact that these individuals have had more exposure to formal testing opportunities within the penal system. 100% of those reporting an AIDS diagnosis state their AIDS status was established in 1999 or later. One quarter of all IRR respondents report having been diagnosed with HIV or AIDS in another state, compared to 57% of the Community group of 'In Care' respondents, again evidencing the extent of migration into the Phoenix area.

'In Care' Respondent Testing/Linkages and Time to Care

Initial reasons supplied for being tested for HIV by 58% of the respondents (N=7) was "jail/prison"; for 25% of all respondents the reason was "I was sick" (4 respondents); followed by 6% "Officials told me I was exposed" (one respondent); and "Admission to hospital/tested there" (1 respondent or 6%). Two persons (12%) were tested upon donating plasma and one respondent (6%) reported reason for testing as "Shelter encouraged me to".

Upon learning their sero-status at the time of their HIV diagnosis, *only one quarter (or 25%) of the 'IRR In Care' respondents report being referred into HIV medical care*. Eight IRR respondents report entering care immediately upon diagnosis (50%); ***while 25% report entry into care occurring more than one year after diagnosis.***

Thirteen of 16 IRR 'In Care' respondents reported seeing their Doctor to treat their HIV disease within the past two months or less; three IRR reported seeing their physician within the past 6-7 months; and ALL of the IRR 'In Care' group reported having had CD4 cell counts and/or viral load testing within the past year. Fifty-percent (50%) of IRR respondents have received dental care services in the past year, with 31% (or five persons) requiring extractions.

Educational Level and Employment Status

Compared to the Community-based 'In Care' population, the IRR 'In Care' population is less well educated, overall. Forty-four percent report completion of high school; 6% hold a college degree; 32% have only some high school/grade school or less formal schooling; and 6% reported no formal schooling whatsoever. All of the IRR population currently report unemployment.

Income Level, Health Insurance and Benefits

All of the IRR respondents report annual income levels at or below 100% of the federal poverty level. The vast majority of all 'IRR In Care' respondents (15 of 16) report having no form of health insurance benefit. Only one respondent reported VA benefits, compared to the Community group, wherein all but one respondent reported having some form of health insurance.

HIV Primary Care Locations

All IRR respondents report receipt of their HIV primary care services on location within the Health Unit of the prison. Forty-five (45%) of all respondents (N=8) report receiving their HIV medical services through McDowell; three persons (17%) receive their HIV primary care through Spectrum; one person (6%) reports receipt of HIV care through Pueblo Scottsdale; and one person (6%) receives their care through Sun Life Family Health Center.

Co-Morbidities

The Pinal 'Incarcerated-In Care' population reports multiple co-morbidities. Like the Community 'In Care' population, thirty percent (30%) of all IRR respondents report multiple other physical health conditions and the majority reports at least one other medical condition, in addition to HIV disease. Six persons or *38% reporting a history of Hepatitis (Hepatitis A (N=1), B (N=1), or C (N=4)*; 6% cardiac conditions; 44% nerve conditions; 12% hypertension; 12% Diabetes; ***and 25% (four persons) report a history of tuberculosis.***

The Pinal 'In Care' population also reports a high level of mental health disorders: five persons or 31% of the IRR sample report depression, a mood disorder, bipolar disorder, schizophrenia, or manic depression. Three persons report having mental health treatment recommended to them and three respondents report receipt of some form of mental health care. Two respondents are currently seeking mental health treatment.

Substance Use

Seven IRR respondents (44%) admit to a history of IDU, including the intravenous use of cocaine, crystal methamphetamine, heroin and 'other'. Six of these seven respondents admit to having shared needles and/or drug paraphernalia with others.

Sexual Activity and Risk

None of the IRR respondents admitted to current sexual activity within the past six months.

One respondent reported having ever paid someone for sex; one respondent admits ever having sex for money, drugs, rent, etc. None of the respondents report ever having been a victim of domestic violence; one respondent reports ever having been a victim of sexual assault.

Sexually Transmitted Diseases (STDs)

ALL (100%) of the IRR 'In Care' population reports a history of STDs. *Only one respondent reported having had an STD diagnosed within the past year.*

The *Incarcerated 'In Care' Needs Assessment Survey results* are discussed in order by the frequency and rankings of expressed service needs, based upon the following definition:

NEED:	Rank order of need frequency among Service Categories *(1 is highest NEED rank)*

The top ranked NEEDS for the Incarcerated 'In Care' population by ALL respondents were:

Table 57: Service NEEDS: ALL Incarcerated 'In Care' Respondents

Service Category Description	Need Freq	Need Frequency	Need Rank
AMBULATORY OUTPATIENT MEDICAL CARE	12	75%	1
HOUSING ASSISTANCE	11	69%	2
DRUG REIMBURSEMENT PROGRAM	10	63%	3
CASE MANAGEMENT	6	38%	4
TRANSPORTATION	4	25%	5
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	2	13%	6
JOB PLACEMENT	1	6%	7
MENTAL HEALTH	1	6%	7
ORAL HEALTH -DENTAL	1	6%	7
SUBSTANCE ABUSE SERVICES	1	6%	7

The top ranked NEEDS for the Incarcerated 'In Care' population by HRH respondents were:

Table 58: Service NEEDS: High Risk Heterosexual Incarcerated 'In Care' Respondents

Service Category Description	Need Freq	Need Frequency	Need Rank
HOUSING ASSISTANCE	9	82%	1
AMBULATORY OUTPATIENT MEDICAL CARE	8	73%	2
DRUG REIMBURSEMENT PROGRAM	8	73%	2
CASE MANAGEMENT	5	45%	3
TRANSPORTATION	3	27%	4
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	2	18%	5
JOB PLACEMENT	1	9%	6
MENTAL HEALTH	1	9%	6
ORAL HEALTH -DENTAL	1	9%	6
SUBSTANCE ABUSE SERVICES	1	9%	6

The top ranked <u>NEEDS</u> for the Incarcerated 'In Care' population by Anglo MSM respondents were:

Table 59: Service NEEDS: Anglo MSM Incarcerated 'In Care' Respondents

Service Category Description	Need Freq	Need Frequency	Need Rank
AMBULATORY OUTPATIENT MEDICAL CARE	1	100%	1
CASE MANAGEMENT	1	100%	1
DRUG REIMBURSEMENT PROGRAM	1	100%	1

The top ranked <u>NEEDS</u> for the Incarcerated 'In Care' population by AA MSM respondents were:

Table 60: Service NEEDS: African American MSM Incarcerated 'In Care' Respondents

Service Category Description	Need Freq	Need Frequency	Need Rank
AMBULATORY OUTPATIENT MEDICAL CARE	2	100%	1
HOUSING ASSISTANCE	1	50%	2
TRANSPORTATION	1	50%	2

The top ranked <u>NEEDS</u> for the Incarcerated 'In Care' population by IDU respondents were:

Table 61: Service NEEDS: IDU Incarcerated 'In Care' Respondents

Service Category Description	Need Freq	Need Frequency	Need Rank
HOUSING ASSISTANCE	4	100%	1
AMBULATORY OUTPATIENT MEDICAL CARE	2	50%	2
TRANSPORTATION	2	50%	2
DRUG REIMBURSEMENT PROGRAM	1	25%	3
FOOD BANK, HOME DELIVERED MEALS, NUTRITIONAL SUPPLEMENTS	1	25%	3
JOB PLACEMENT	1	25%	3

Among the Severe Need Groups, the top ranking priority NEEDS are identical, though some services receive higher rank ordering than others. Consistently, ALL of the Incarcerated 'In Care' population, and each of the Severe Need Groups identify Ambulatory Medical Care, Housing Assistance, Food Bank Services, Transportation, Medications, and Job placement as priority NEEDS.

Case management, oral health, mental health and substance abuse services also receive high rankings as priority NEEDS by members of the Incarcerated 'In Care' population.

Chapter 4 Out of Care[7] Findings

1.Introduction

A comprehensive assessment of the service needs of persons living with HIV/AIDS and residing in Pinal County of the Phoenix EMA was conducted in January through March of 2006. This 'Out of Care' Needs Assessment was developed using a consumer survey for determining the needs, gaps and barriers to care for those individuals NOT in care. 'In Care' is defined in the footnote below using HRSA's (Health Resources Services Administration's) definition of NOT in care over the previous 12 month period. This narrative describes the process and findings of the 'Out of Care' (OOC) needs assessment, with detail by HRSA defined Severe Need Groups (SNGs) listed and defined in the legend on the next page.

In the 'Out of Care' population, two (2) categories were identified:

(1) Individuals who have been in a Ryan White or other care system, but have NOT received primary care services in the past six to twelve (6-12) months—'erratically in care'; and

(2) Individuals who have known their HIV status for some time, but either have NEVER entered care and received primary medical care services or have been 'out of care' for a period of time longer than one year.

HRSA's CARE Act Amendments of 2000 emphasize the identification of those individuals who "know their HIV status and are NOT receiving HIV-related services (those with 'unmet need')."

Using Arizona Department of Health HARS (HIV & AIDS Reporting System) data, the number of persons living with HIV/AIDS in Pinal County was determined to be 331 (2005 Integrated Epidemiologic Profile). Approximately 30% of these prevalent HIV/AIDS cases (N=99) reside in the prison setting in Pinal County. Based upon State's 'unmet need' data, the total number of unduplicated PLWHA receiving Ryan White funded services ('In Care In System') is currently estimated to be 115. The estimated number of PLWHA receiving primary care services funded through other third party payors (defined as 'In Care/Out of System') is currently unknown. The remaining 170 PLWHA are considered 'Out Of Care'. The following table provides a care status breakdown for the total PLWHA within Pinal County.

Care Status	In Care Ryan White	In Care non Ryan White	Out of Care	Total PLWHA
Client Count	**115***	**?**	**170**	**331***
Facility	**McDowell and other RW funded providers**	**Medicare, Private Insurance, Prison Service**	**No CD4, Viral Load, ART in the past 12 months**	

**ADHS 2003 Unmet Needs Data and 2005 Integrated Epidemiologic Profile*

[7] Out of Care – defined by HRSA as NOT receiving primary medical care for period over 12 months. Primary medical care defined as receiving 1) Viral Load tests 2) CD4 Count 3) Antiretroviral drugs.
(See Appendix B: Out of Care Survey)

The goal of the 'Out of Care' survey process was to achieve a 10% participation rate (N=17) by the total OOC clients (N=170), hereafter referred to as 'Out of Care' population. The actual 'Out of Care' participation rate was 9% (N=15).

2.Methodology-Out of Care Survey

a. Survey Recruitment

The goal of the 'Out of Care' needs assessment was to maximize, to the extent possible, the participation of OOC survey respondents in order to better understand those PLWHA with 'unmet need'. Recruitment posters were used to promote the survey. It was the expressed intent of the Planning Council to make every attempt, in the time available, to survey these hard-to-reach populations. All survey respondents were sent a $20 gift certificate upon completion of the telephone survey interview process.

b. Survey Administration

The survey was administered via PLWHA contact with a trained facilitator using a 1-800 toll-free line. Surveys typically took 20 minutes, with some detailed discussions lasting up to 30 minutes. All surveys were verbally administered, which eliminated the need for respondents to be literate and allowed for facilitator assistance in completing the questionnaire. The toll-free access allowed for a sense of anonymity, and facilitated the free offer of confidential personal information and attitudes.

c. Analysis

Responses were analyzed for the entire respondent pool, and then were divided by Severe Need Group to identify variations in service needs and barriers. There were 15 respondents to the 'Out of Care' survey, with the breakdown by Severe Need Group (displayed below).

Out of Care Survey Respondent Profile

6. Demographic and Health Profile of 'Out of Care" Respondents

Of the total OOC sample, 15 respondents were Male (100%). Over half (53%) of the entire OOC population identifies as Homosexual/Gay; 27% as Heterosexual, and 20% as Bisexual. An additional 4 respondents (27%) report a history of IDU. The entire OOC population was between the ages of 25 and 54 years. The racial/ethnic make-up of the 'Out of Care' population is entirely Anglo/Caucasian.

Table 62. OOC Survey Respondent Profile

Out Of Care:			
Severe Need Group	'n'	%	Demographic Profile (Gender/Race/Risk)
Anglo MSM	8	53%	8 Anglo Male MSM
HET MALE	4	27%	4 Anglo Male HET
IDU	4	27%	2 Male Anglo HET; 2 Male Anglo MSM
TOTAL	*15	100%	

**** More than one SNG category represented in some cases***

LEGEND:

AA MSM	African American MSM
Anglo MSM	Caucasian MSM
HIS MSM	Hispanic MSM
Het Male	Heterosexual Male
WCB	Women of Childbearing Age (15-44 years)
IRR	Incarcerated/ Recently Released
SA	Substance Abuser
IDU	Injection Drug User

Employment, Education Level, Income Level and Health Benefits

Only 6% (1 respondent) of the 'Out of Care' population reports being currently unemployed. The remainder of the sample group preferred not to answer this question.

Overall, the OOC population is a less well-educated group of individuals than the Community 'In Care' population. Two-thirds of the OOC population report some high school or grade school or less. Five persons (33%) report having a college degree.

Table 63: Education Level of OOC Client Respondents

Education Level	#	%
Grade school or less	2	13%
Some high school	8	53%
High school grad/GED	0	0%
Some College	0	0%
College degree	5	33%
TOTAL	**15**	**100%**

Fifty-three percent (53% or 8 respondents) have acquired Medicaid and/or Medicare benefits, presumably on the basis of disability for the majority of beneficiaries. None of the OOC respondents have private insurance; and *7 respondents (47%) report having no form of health insurance benefit (compared to 6% (or one individual) of the Community 'In Care' survey sample).* ***Eighty percent (80%) of the 'Out of Care' population (12 of 15 total respondents) are living in poverty, reporting incomes ranging from $0-19,999,with five persons reporting incomes at or below 200% of the federal poverty level (FPL), and seven persons living at 100% of the FPL or less***. (Three persons did not answer.)

Residence and Living Arrangements

None of the OOC respondents own their own home. The vast majority (14 of 15 respondents) are temporarily housed, living with a friend or relative; and 7% (1 respondent) is housed in jail. *One third (33%) of the OOC respondents report a period of recent homelessness within the past two years.* This level of housing instability for a substantial portion of the 'Out of Care' population obviously contributes to erratic engagement in primary medical services.

Four (4) zip codes were identified as the residence of 100% of the respondents to the 'Out of Care' survey, with one individual reporting "jail" as current residence.

Table 64: Geographic Residence (by ZIP CODE) of OOC Survey Respondents

City	Zip	#	%
Casa Grande	85222	5	33%
Apache Junction	85219	4	27%
Mammoth	85618	5	33%
ADC-North	Jail	1	7%
TOTAL		15	100%

HIV/AIDS Status

Eighty percent (80%) of the 'Out of Care' population report living with HIV (N=12) and 13% report living with AIDS (N=2). One individual (7%) is not certain of his HIV/AIDS status. Year of HIV diagnosis ranged from 1994 to 2003, yielding a fairly wide range for reported length of time since diagnosis. One individual was diagnosed with AIDS in 1999 and the other in 2003. Twenty percent of the OOC population (N=3) was diagnosed out of state (in Illinois and California).

Length of Time Since Regularly in Care & Previous Primary Care Provider

Forty percent of the 'Out of Care' respondents have been absent from care for a period of six to 12 months (six respondents), and 60% of the OOC respondents have not seen a physician or had HIV laboratory monitoring for over 12 months, and longer. *All of the OOC sample has been in care at some time since their diagnosis. None of the OOC sample has had laboratory testing in the past 12 months (neither a CD4 cell count or viral load test.). Previous primary care providers reported by the OOC population include: Sun Life Family Health Center (5 or 33%); McDowell (4 or 27%); other physicians (4 or 27%); and two persons who preferred not to answer this question.*

HIV Testing Circumstances

Over one-half of the OOC respondents (53%) tested HIV positive and learned their sero-status in an HIV Counseling/Testing site. The remainder (47%) reported learning their sero-status as the result of HIV testing upon entry into the military or upon donating blood.

Reasons for Seeking/Receiving HIV Testing

The prime motivating factor for seeking/receiving an HIV test for one-third of the 'Out of Care' respondents (5 persons or 33% of the total population) was illness ("I was sick"). An additional twenty percent (20%) of respondents reported "My partner told me to". Testing upon blood donation was the reason for three persons (20%) and a military requirement for testing constituted the reason for testing for four OOC individuals (27%).

Referral Into and Linkage Mechanisms With Primary Medical Care

None of the OOC sample answered the question regarding referral into primary medical care upon diagnosis. However, four individuals did report entering care within 1-3 months of diagnosis. The remainder of the OOC sample preferred not to answer this question. None of the OOC sample offered reasons for their delay into medical care. Without a direct referral into primary medical care, with much follow-up, it is unlikely that a substantial proportion of the already hard-to-engage members of the Severe Need Groups will successfully enter into and remain in care.

Length of Time Testing/Referral Into Care

Only 27% or 4 OOC respondents met the HRSA/CDC goal of entry into care within three months of diagnosis with HIV disease. It is unknown how many of the OOC sample population did not enter care for more than one year following their HIV diagnosis.

Current Mental & Physical Health Status of OOC Population

Over one quarter (27%) of the 'Out of Care' population reports having been diagnosed with and/or treated for a **mental illness, including depression, mood disorders, bipolar disorder, schizophrenia and manic depression**. Fifty-three percent of all OOC respondents report that mental health treatment had been recommended to them, and four persons (27%) report ever receiving mental health treatment. Four persons are currently seeking treatment for their mental health disorders.

Medical Co-Morbidities

Medical co-morbidities were less frequently cited among the OOC population than either of the 'In Care' populations. Nine OOC respondents (or 64%) of the total OOC population) reported a diagnosis High Blood Pressure; five persons (33%) reported 'nerve' problems; four OOC persons report history of neuropathy; and three persons reported lipodystrophy. These last two conditions are associated with side effects of antiretroviral medications.

'Out of Care' Service Needs, Service Uses, Service Gaps and Service Barriers

The 'Out of Care' Needs Assessment Survey results are discussed in order by the frequency and rankings of expressed service needs and service gaps based upon the following definitions:

NEED:	**Rank order of need frequency among Service Categories *(1 is highest NEED rank)***
USE:	**Rank order of use frequency among Service Categories *(1 is highest USE rank)***
GAP:	**Rank order among Respondents who indicated NEED and NO ACCESS to this Service Category *(1 is highest GAP rank)***
BARRIER:	**Rank order among Respondents who indicated NEED but Hard to ACCESS *(1 is highest BARRIER rank)***

7. ***The top three ranked NEEDS and four top ranked USES for ALL 'Out of Care' respondents were:***

Table 65: NEEDS and USES for ALL 'Out of Care' Respondents

Service Category Description	Need Freq	Need Frequency	Need Rank	Use Freq	Use Frequency	Use Rank
HOUSING ASSISTANCE	4	100%	1	8	53%	1
AMBULATORY OUTPATIENT MEDICAL CARE	5	33%	2	5	33%	2
OUTREACH	3	20%	3	3	20%	3
CASE MANAGEMENT	0	0%	4	1	1%	4

Table 66: Top Priority NEEDS and USES by Anglo MSM SNG

Service Category Description	Need Freq	Need Frequency	Need Rank	Use Freq	Use Frequency	Use Rank
TRANSPORTATION	2	25%	1	0	0%	3
AMBULATORY OUTPATIENT MEDICAL CARE	1	13%	2	3	38%	1
OUTREACH	0	0%	3	2	25%	2

Table 67: Top Priority NEEDS and USES by High Risk HET SNG

Service Category Description	Need Freq	Need Frequency	Need Rank	Use Freq	Use Frequency	Use Rank
HOUSING ASSISTANCE	4	80%	1	0	0%	2
AMBULATORY OUTPATIENT MEDICAL CARE	3	60%	2	2	40%	1

Table 68: Top Priority NEEDS and USES by IDU SNG

Service Category Description	Need Freq	Need Frequency	Need Rank	Use Freq	Use Frequency	Use Rank
HOUSING ASSISTANCE	4	100%	1	4	100%	1
OUTREACH	2	50%	2	0	0%	2

The **Needs** rankings of the Severe Need Groups are highly congruent, overall, with the expressed needs of the entire 'Out of Care' population. This consistent expression of need is particularly evident in the number of *top three NEED rankings for primary medical care, housing assistance and outreach.*

5.a. The top ranked and only GAP in Services perceived as unavailable by ALL'Out of Care' respondents was 'job placement services':

Table 69: GAP Perceived by ALL 'Out of Care' Respondents

Service Category Description	Gap Freq	Gap Frequency	Gap Rank
JOB PLACEMENT	3	20%	1

5.b. Reasons given by the entire OOC population for why job placement services are unavailable include:

Table 70: GAP Explanations

GAP Explanations	#	%
RURAL LOCATION	10	77%
SERVICE REIMBURSEMENT DISCONTINUED	1	8%
INSURANCE	1	8%
INCOME ABOVE REQUIREMENT	1	8%
TOTAL	**13**	**100%**

5.c. Top Priority GAP Rankings by Severe Need Groups:

- **Anglo MSM: Oral Health/Dental Services**
- **HRH: Oral Health/Dental Care Services**
- **IDU: Job Placement Services**

6a. The top and only Service BARRIER identified as 'hard to get' by the entire OOC population includes Oral Health/Dental Care Services:

Table 71: Top BARRIER for ALL OOC Respondents

SERVICES	#	%
DENTAL CARE	8	100%
TOTAL	**8**	**100%**

6.b. Reasons supplied by the OOC population for this perceived dental care service barrier include:

Table 72: BARRIER Explanations Offered by OOC Respondents

Barrier Explanations	#	%
JUST NOT EASILY ACCESSIBLE	3	38%
TRANSPORTATION	4	50%
INCOME ELIGIBILITY	1	13%
Totals	**8**	**100%**

For the Severe Need Groups, perceived GAPS and BARRIERS are consistently Dental Care Services and Job Placement Services, ranking highest for the services perceived as either unavailable or hard to access.

Chapter 5: Comparison of Findings Between Needs Assessments

A total of three Pinal County needs assessments have now been conducted, among the Community "In Care' population, the Incarcerated 'In Care' population and the 'Out of Care' population, yielding rich baseline data for planners and providers, alike.

The Tables below document the Respondent Profiles by Severe Need Groups for each of the three 2006 Needs Assessments.

2006 Community 'In Care' vs Incarcerated 'In Care' vs 'Out of Care' Respondent Profiles

Table 73: Community 'In Care' Survey Respondent Profile

Severe Need Group	#	%
AA MSM	2	6%
Anglo MSM	7	23%
His MSM	4	13%
High Risk HET	10	33%
WCB	5	16%
IDU	3	10%
TOTAL	**30**	**100%**

LEGEND:

AA MSM	**African American MSM**
Anglo MSM	**Caucasian MSM**
API MSM	**Asian Pacific Islander APM**
HIS MSM	**Hispanic MSM**
High Risk HET	**High Risk Heterosexuals**
WCB	**Women of Childbearing Age (15-44 years)**
IRR	**Incarcerated/ Recently Released**
SA	**Substance Abuser**
IDU	**Injection Drug User**

Table 74: Incarcerated 'In Care' Survey Respondent Profile

Severe Need Group	#	%
AA MSM	2	6%
Anglo MSM	1	23%
High Risk HET	9	33%
IDU	4	10%
IRR TOTAL	**16**	**100%**

Table 75: Out of Care Survey Respondent Profile

Severe Need Group	'n'	%	Demographic Profile (Gender/Race/Risk)
Anglo MSM	**8**	**53%**	8 Anglo Male MSM
HET MALE	**4**	**27%**	4 Anglo Male HET
IDU	**4**	**27%**	2 Male Anglo HET; 2 Male Anglo MSM
TOTAL	***15**	**100%**	

The following narrative compares and contrasts the unique findings and trends, as indicated, among the needs, uses, gaps and barriers as perceived by the three special populations. The comparisons of the two 'In Care' Needs Assessment Survey findings (for the Community 'In Care' and the Incarcerated 'In Care groups) and the one 'Out of Care' Needs Assessment results are discussed in order by the frequency and rankings of expressed service needs, service usage, service gaps and service barriers based upon the following definitions:

NEED:	Rank order of need frequency among Service Categories *(1 is highest NEED rank)*
USE:	Rank order of use among Service Categories *(1 is highest USE rank)*
GAP:	Rank order among Respondents who indicated NEED and NO ACCESS to this Service Category *(1 is highest GAP rank)*
BARRIER:	Rank order among Respondents who indicated NEED and HARD TO ACCESS this Service Category *(1 is highest BARRIER rank)*

NEEDS:

The table on the following page shows Need, as reported by the total 'In Care' Community survey group, the total 'In Care' Incarcerated group, and the total 'Out of Care' survey group.

Table 76: Pinal County 2006 NEEDS Matrix

PINAL COUNTY	2006 NEEDS	Assessment	Matrix
Community In Care		Incarcerated In Care	Out of Care
N=30		N=16	N=15
2006 Rank	Service Category	2006 Rank	2006 Rank
1	Ambulatory Medical Care	1	2
2	Housing Assistance	2	1
3	Oral Health	7	NR
4	Drug Reimbursement	3	NR
5	Case Management	4	NR
6	Food Bank Services	6	NR
7	Transportation	5	NR
7	Specialty Medical	NR	NR
7	Mental Health	7	NR
7	Job Placement	7	NR
7	Substance Abuse Services	7	NR
7	Buddy/Companion	NR	NR
7	Housing Related Services	NR	NR
7	Psychosocial Support	NR	NR
7	Support Groups	NR	NR
7	Emergency Financial Assistance	NR	NR
7	Outreach	NR	3

- No ranking offered for this Service Category

Clusters of Need become more readily apparent when viewed in the matrix format. There is great consistency between both the Community and Incarcerated 'In Care' populations as to top priority NEEDS. The OOC population shares the top two perceived needs of Ambulatory Medical Care and Housing Assistance, differing from the 'In Care' groups only with regard to Outreach Services.

GAPS: The table below shows GAPS, as reported by the total 'In Care' Community survey group, the total 'In Care' Incarcerated group, and the total 'Out of Care' survey group.

Table 77: Pinal County 2006 GAPS Matrix

PINAL COUNTY	2006 GAPS	Assessment	Matrix
Community In Care		Incarcerated In Care	Out of Care
N=30		N=16	N=15
2006 Rank	Service Category	2006 Rank	2006 Rank
1	Specialty Medical	NR	NR
2	Vision Care	NR	NR
3	Food Bank	NR	NR
4	Support Groups	NR	NR
5	Oral Health	NR	NR
6	Housing Assistance	NR	NR
6	Emergency Financial Assistance	NR	NR
6	Alternative Therapies	NR	NR
6	Job Placement	NR	1
6	Rural Access	NR	NR

- No ranking offered for this Service Category

Only one of the top GAPS identified by the Community 'In Care' population is also shared by the 'Out of Care' population: Job placement Services. The Incarcerated 'In Care' population did not supply any rankings for perceived GAPS.

BARRIERS: The table below shows Need, as reported by the total 'In Care' Community survey group, the total 'In Care' Incarcerated group, and the total 'Out of Care' survey group.

Table 78: Pinal County 2006 BARRIERS Matrix

PINAL COUNTY	2006 BARRIERS	Assessment	Matrix
Community In Care		Incarcerated In Care	Out of Care
N=30		N=16	N=15
2006 Rank	Service Category	2006 Rank	2006 Rank
1	Transportation	NR	NR
2	Oral Health	NR	1
3	Drug Reimbursement	NR	NR
4	Housing Assistance	NR	NR
4	Specialty Medical	NR	NR
5	Emergency Financial Assistance	NR	NR
5	Cleaning	NR	NR
5	Support Groups	NR	NR
5	Mental Health	NR	NR
5	Food Bank	NR	NR

- No ranking offered for this Service Category

The Community 'In Care' Respondents identified 10 services that are 'hard to get' as their top five ranking BARRIERS. The Incarcerated 'In Care' Respondents did not supply any service barrier rankings. The 'Out of Care' Respondents cited only one service that is 'hard to get': that of Oral Health/Dental Care Services.

Chapter 6: Recommendations

Based on data contained in this report, the following recommendations are proposed to reduce health care disparities and increase access to core services for Pinal County PLWHA:

- Increase Core Service Capacity in Pinal County

- Develop a Continuum of Care for Pinal County PLWHA (based on NA findings)
  - Primary Medical Care
  - Case Management (existing)
  - Support Groups (ie: Apache Junction)
  - Oral Health Services
  - Transportation (examine past utilization provided by Grantee)

- Strengthen "referral" of IRR as they transition based upon parole assignment (Release Planning/Pinal County Public Health/MOSAIC)
  - Out of Care IRR soon to be released

- Develop a linguistically and culturally appropriate Resource Guide for Pinal County PLWHA